

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 5 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY M. ABBOT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 21, 1982</b>		2b. HOUR P <b>9:55 M</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 21, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARRIAGE HILL-BETHESDA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>			13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clinton Hart Merriam</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Gosnell</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-60-9128</b>		17. INFORMANT ADDRESS <b>Mr. Henry M. Abbot, Son, 4924 Sentinel Dr., Sumner, MD.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Influenza**

DUE TO, OR AS A CONSEQUENCE OF

(b)

**Diabetes Mellitis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

**Generalized Aterteriosclerosis**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **a**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>Jan. 21, 1982</b> , that (I) <b>XX</b> lost saw the deceased alive on <b>Jan 14, 1982</b> , and that in (my) <b>XX</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>XX</b> (did <b>NOT</b> ) view the body after death.					
22b. SIGNATURE <i>Charles P. Duvall, M.D.</i> DEGREE				22c. DATE SIGNED <b>Jan. 21, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles P. Duvall, M.D.</b>				22e. ADDRESS <b>3301 New Mexico Avenue, N.W. Washington, D.C. 20016</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>Jan. 24, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory, Alexandria, Virginia</b>	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 27 1982</b> <i>Frances Jean Nathan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNITED STATES MARINE CORPS

100-1100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 0 5 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1-16-82 554 P.M.			
1. DECEASED NAME FIRST MIDDLE LAST Hazel C. Ablon				2b. DATE OF DEATH MONTH DAY YEAR 1-16-82 554 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 8 09		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. 41 DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OKLAHOMA		7b. CITIZEN OF WHAT COUNTRY? American		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASH. ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesperson		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
14. FATHER'S NAME FIRST MIDDLE LAST James Compton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Allison			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 460-72-9222		17. INFORMANT ADDRESS Md. Carol Pensky; 12712 Huntsman Way; Potomac,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Aspiration Pneumonia 3352							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO, OR AS A CONSEQUENCE OF (b) Angiographic lateral Sclerosis							1 year
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from NOV. 2, 1979, to JAN. 16, 1982, that (I) (we) last saw the deceased alive on JAN. 15, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 22c. DEGREE 22d. DATE SIGNED 1/16/82				22e. ADDRESS 10500 Summit Ave, Kensington Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-1982		23c. NAME OF CEMETERY OR CREMATORY Tifereth Israel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Dallas, Texas	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

1954-55

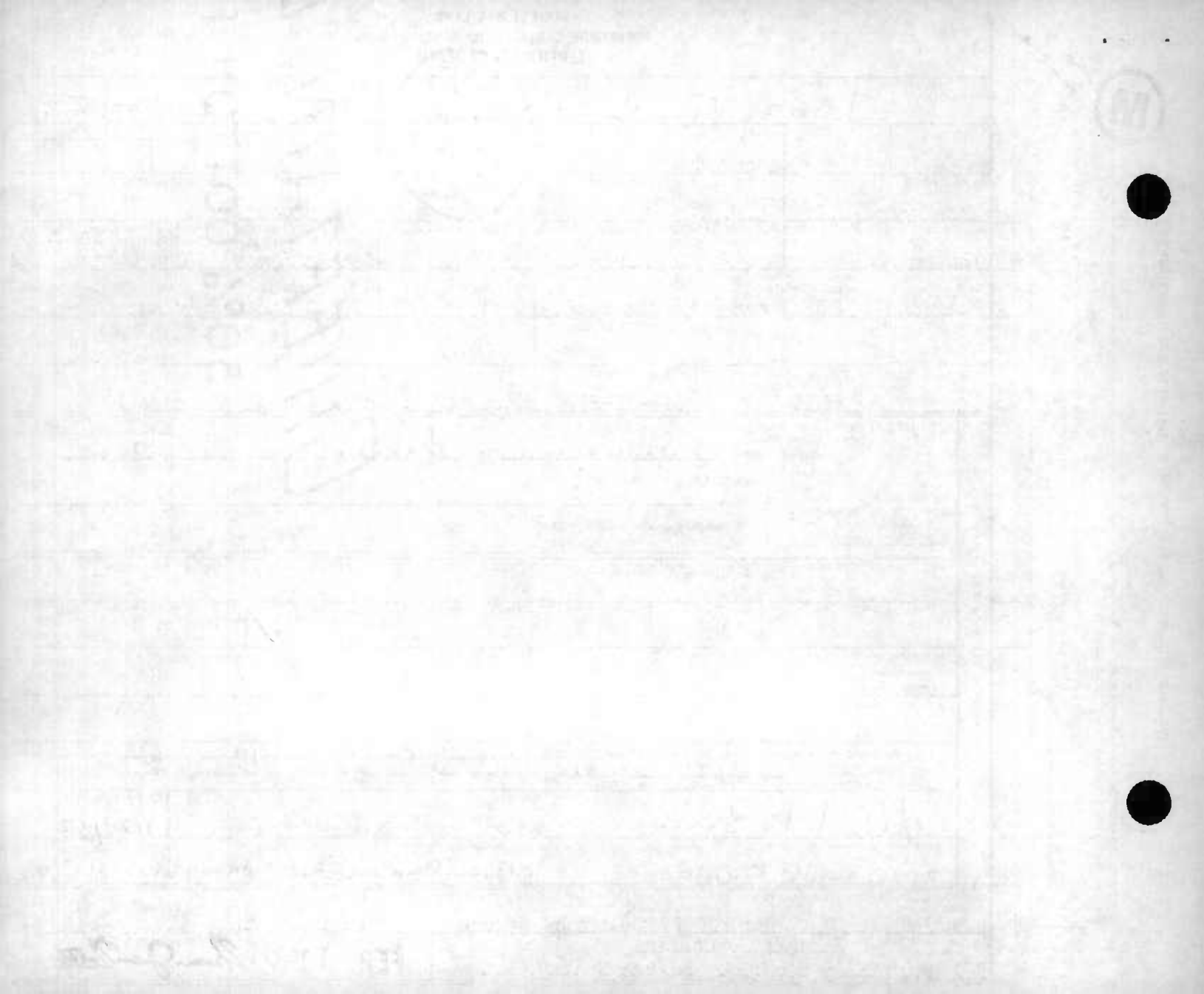


1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>James Francis Acton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 27 1982</b>		2b. HOUR <b>3:30 P.M.</b>
3 SEX <b>male</b>	4 RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 18, 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Corrections Officer Corrections</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9602 Bristol Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James C. Acton</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary F. Boswell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WWII 579-12-8990</b>		17. INFORMANT ADDRESS <b>Margaret L. Acton Wife Same as 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>82</b> , to <b>1/20</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Michael C. Bruce</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KIRKLAND C. BRACE</b>		22e. ADDRESS <b>17600 CARROLL AVE TAKOMA PARK, MD 20912</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 30, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins 500 University Blvd., W. Silver Spring, Md.</b>			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>		25c. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>	



M

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edgar C Adcock</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1 5 82</i>		2b. HOUR MIN. <i>5 24 P</i>				
3. SEX <i>m</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 12 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>89</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>ENGLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>PLUMBER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>SAME</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>TAKOMA PARK</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>702 SLIGO CREEK PARKWAY</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOHN C. ADCOCK</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>MINNIE</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>577-03-0967</i>		17. INFORMANT ADDRESS <i>MARY H. ROBERSON, 702 SLIGO CREEK PARKWAY</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> <i>4280</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia Aspiration</i> (c) <i>Coronary Cardiac Failure</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus, Carcinoma Prostate, C.O.P.D.</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. certify that (I) (this hospital) attended the deceased from <i>12/23</i> , 19 <i>81</i> , to <i>1/5</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>Jan. 3, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Michael...</i>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/5/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Virex C VAID</i>				22e. ADDRESS <i>7676 New Hampshire Ave.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 8, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>Takoma Funeral Home, J. J. ...</i>				ADDRESS <i>2500 ... NW DC</i>		25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>JAN 11 1982 Frances Jan ...</i>			

1. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

3. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or an autopsy must be performed.



[Faint, illegible text throughout the page, likely bleed-through from the reverse side. Some fragments are visible in the bottom left corner, including what appears to be a date 'JAN 1961' and some numbers.]



Released by Dr. Bob Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 0 5 6			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST Robert		MIDDLE R		LAST Addie		2a. DATE OF DEATH		MONTH 1	DAY 18	YEAR 82	2b. HOUR 11:15 PM
3 SEX Male		4 RACE White		5. DATE OF BIRTH		MONTH Feb. 6		YEAR 1910		6 AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10 CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Reporter		12b. KIND OF BUSINESS OR INDUSTRY Newspaper	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8611 Beach Tree Road							
14 FATHER'S NAME FIRST Antonio		MIDDLE		LAST Addie		15 MOTHER'S MAIDEN NAME FIRST Unknown		MIDDLE		LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO WW1 & Korea 063-09-4045		17 INFORMANT ADDRESS Pauline Addie, Same as item 13.									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5570 CARDIO RESPIRATORY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MINS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ACIDOSIS, ELECTROLYTE ABNORMALITY												1 wk	
(c) GANGRENOUS SMALL BOWEL												2 mos	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from July 19 77 to 1-18 19 82, that (I) (we) last saw the deceased alive on 1-15 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Thomas H. Sinderson MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 1-19-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/1982		23c. NAME OF CEMETERY OR CREMATORY St. Gabriel Cemetery		23d. LOCATION CITY OR TOWN POTOMAC		COUNTY Maryland		STATE			
24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc.		NAME 5130 Wisc. Ave.,		ADDRESS ash., D.C.		25a. DATE REC'D. BY REGISTRAR JAN 25 1982		SIGNATURE					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 0 5 7	
1. DECEASED NAME (TYPE OR PRINT) <b>GLADSTONE ELEM ADDO</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>JAN. 25 19 82</b>		2b. HOUR <b>M</b>			
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOV. 1 53</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>28</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD <b>JAN. 25 19 82</b>		2d. HOUR <b>M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NIGERIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>NIGERIA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>STUDENT</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1332 WINDING WAY LANE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown ADDO</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>EMBASSY CONSULAR</b> <b>MAHMUD BAUCHI 2201 M St., N.W. WASH., D.C.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STATUS ASTHMATICUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4939</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>NONE</b>											
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER				DATE SIGNED <b>JAN. 25, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS, M.D.</b>		ADDRESS <b>1919 SEMINARY ROAD SILVER SPRING, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>2-9-82</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN <b>LAGOS</b> COUNTY <b>NIGERIA</b> STATE					
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				500 UNIV. BLVD., WEST, SILVER SPRING, MD.		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>			

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FEDERAL BUREAU OF INVESTIGATION

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JAN 10 1964  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 5 8

REG. NO.

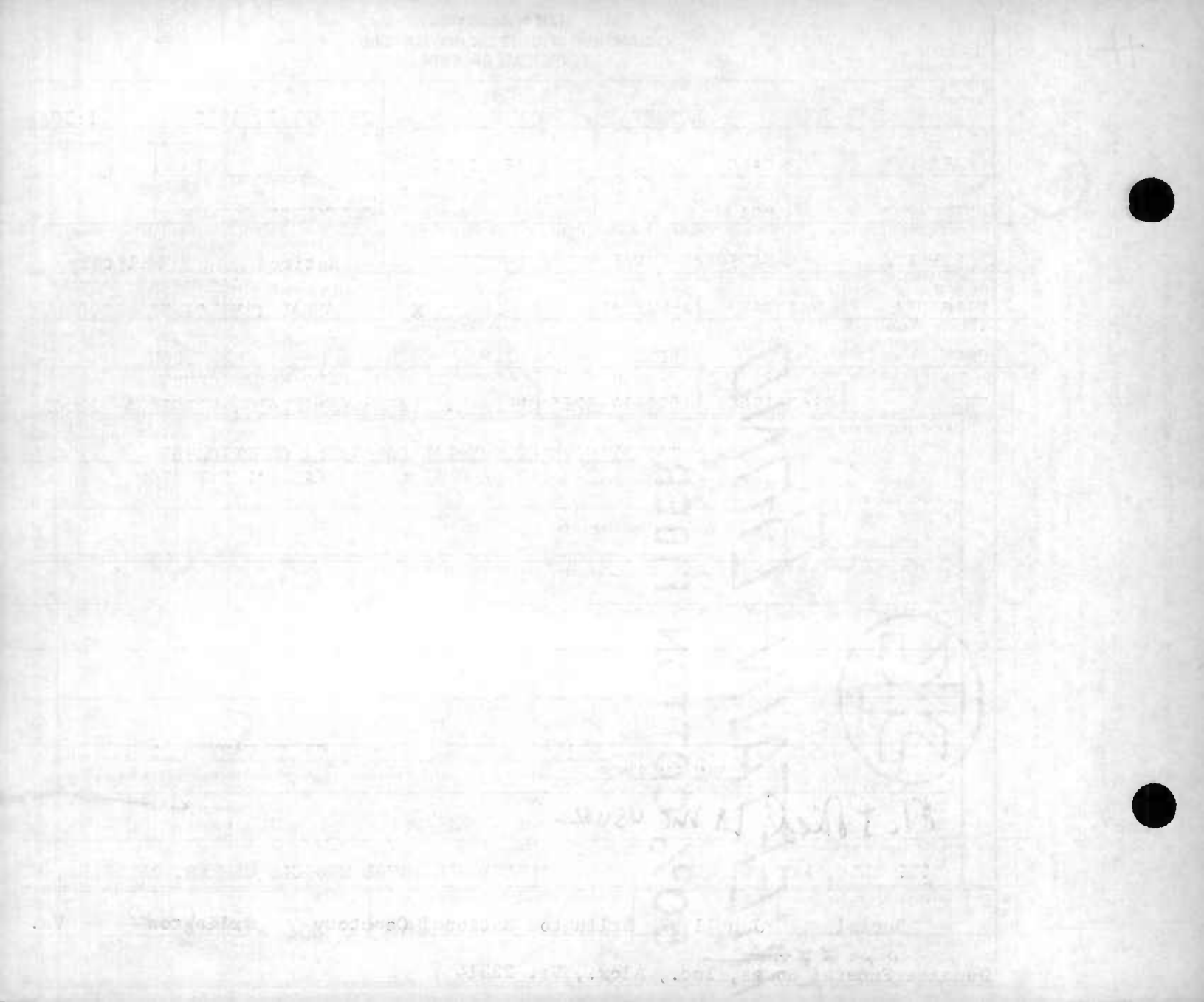
1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN ROBERT AHERN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 7, 1982</b>		2b. HOUR <b>11:30 a.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 17, 1920</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>61</b> YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEBRASKA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VIRGINIA</b>			13b. COUNTY <b>FAIRFAX</b>	13c. CITY OR TOWN <b>ANNANDALE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACK AHERN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WILMA NEDROW</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>9143-1966</b>		
17. INFORMANT <b>VEDA M. AHERN: ANNANDALE, VIRGINIA 22003</b>			18. ADDRESS <b>8402 KENAN COURT</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC BRONCHOAVOLAR CARCINOMA COMPLICATED</b> DUE TO, OR AS A CONSEQUENCE OF <b>BY SANGUINIOUS PERICARDIAL EFFUSION</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12 DECEMBER 19 81</b> , to <b>07 JANUARY 19 82</b> , that (I) (we) lost saw the deceased alive on <b>07 JANUARY 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>H.L. Reed Lt MC USNR</i>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H.L. REED, LT, MC, USNR</b>		22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Jan 11 82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>
24. FUNERAL DIRECTOR NAME <i>Wayne F. F. Smith</i> ADDRESS <b>Demaine Funeral Homes, Inc., Alex., Va. 22314</b>		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 5 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Vincent James Aiello, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 9 82</b>		2b. HOUR <b>3:26 AM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>06 22 22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Ct.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Steady Grove Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>president</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>tile co.</b>	
13a. STATE <b>md</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Angelo Gaither</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Elia</b>		13e. STREET ADDRESS <b>19017 HARRIS LA.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES) <b>yes WW II</b>		16b. SOCIAL SECURITY NO. <b>057-14-7262</b>	17. INFORMANT <b>Gaithersburg, Md.</b> <b>Philip Aiello 388 W. Deerpark Dr.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> 2030 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Plasmodium obstructing Airway</b> minutes DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myeloma</b> years					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>1975</b> , 19 <b>1/9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen J. Newman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/9/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen J. Newman</b>		22e. ADDRESS <b>19261 Montgomery Village Ave.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/12/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>	
24. FUNERAL HOME OR OTHER PLACE OF DISPOSITION <b>Lynson Wheeler Funeral Home, Inc.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JAN 13 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>	
1331 Rockville Pike Rockville, Maryland					

BP

1937 Rockville Pike Rockville, Maryland  
Jason Wheeler Funeral Home, Inc.  
1/12/85

Northwood Memorial Park Rockville, Maryland



you

PM 11

027-14-265

Phillips Atello 365 W. Coopers Dr.

Angelo

Atello

Elizabeth

Atello

BRIDGEPORT, MD.

President

New York USA

1937

James A. Jones



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in person.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR <b>ANNETTE ALFANDRE</b>					8 2 0 2 0 6 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>ANNETTE ALFANDRE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 10, 1982</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 8, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		2b. HOUR <b>8:00 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>#2 Grovepoint Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#2 Grovepoint Court</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nelson Henry</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Stelling</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-42-4425</b>		17. INFORMANT ADDRESS <b>Jack Alfandre 6928 Barrett La. Beth., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292 Atherosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>50 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NONE</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>1/7</b> , 19 <b>82</b> , to <b>1/10</b> , 19 <b>82</b> , that (1) (we) lost above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>S. Ralph Himmelhoch</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/10/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. Ralph Himmelhoch, M.D.</b>					22e. ADDRESS <b>11510 Old Georgetown Rd.-Rockville, Md. 20852</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 13, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION <b>Suitland, Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jos. Gawler's Sons, Inc. 5130 Wisconsin Avenue, N.W.-Washington, D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>				
					25b. REGISTRAR'S SIGNATURE <b>James J. Thornton</b>				





12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 0 6 1	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) George Wallace Allen										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/8 19 82	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 1/8 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3414 Chiswick Court, #46C				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Merchant			12b. KIND OF BUSINESS OR INDUSTRY Office Sup.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3414 Chiswick Court, #46C			
14. FATHER'S NAME FIRST MIDDLE LAST William F. Allen					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva -- Raybold						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. -- 577-03-3005		17. INFORMANT Barbara A. Mooser			ADDRESS 6212 Poindexter La. Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) M.D. Deputy				DATE SIGNED 1/8/82			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-11-82		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood-Prince Geo. Co.-Md.			
24. FUNERAL DIRECTOR Jos. Gawler's Sons, Inc.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
5130 Wisconsin Ave., N.W.-Washington, D.C.						JAN 13 1982		Phonca Jan. Nathan			



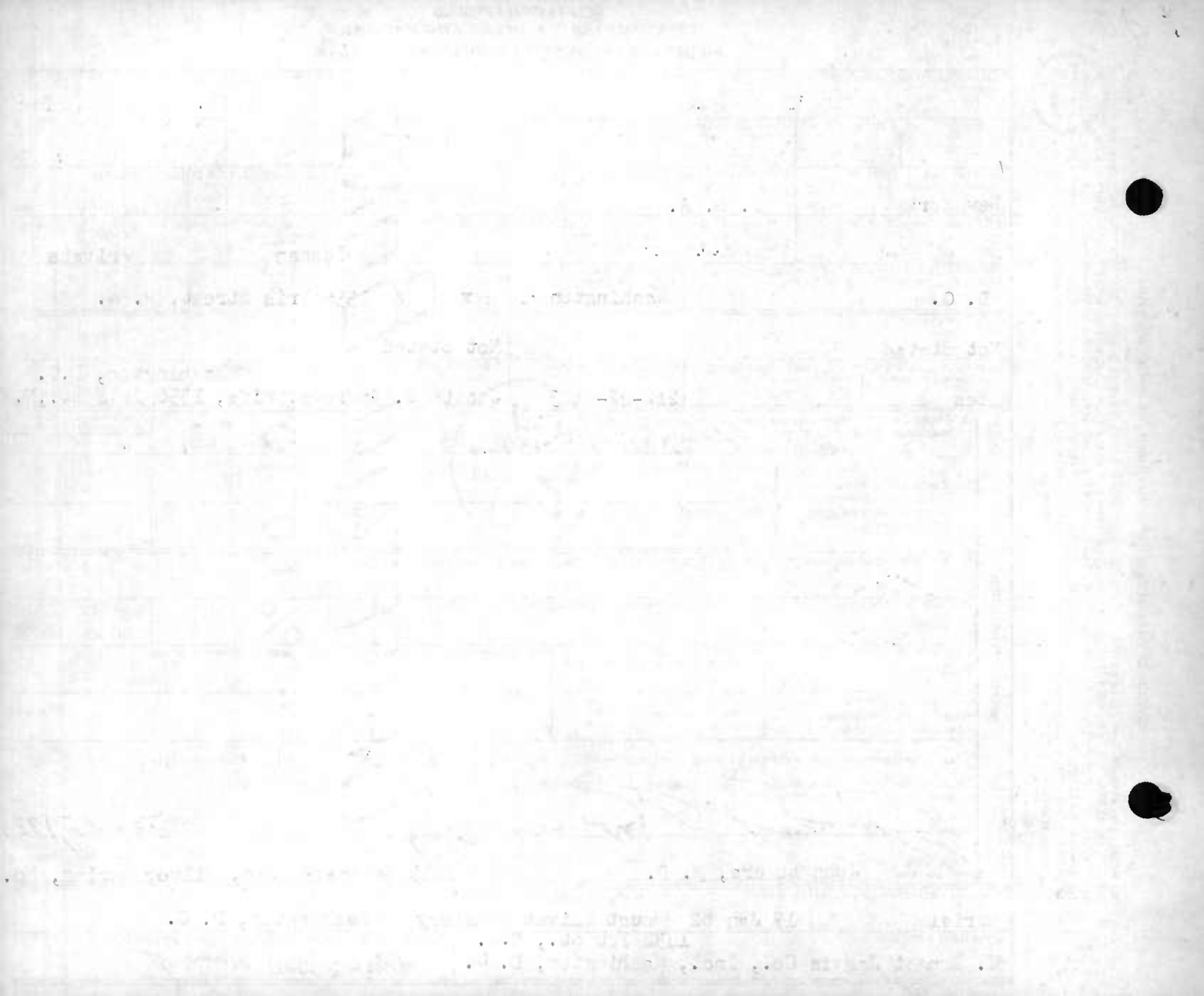
DHMH - 17  
(VR A15 ME (5))  
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
RONALD EGAR ANDREWS		Jan. 15 19 82		12:40							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH	11. DAY	12. YEAR	13. HOUR	14. MIN.
M	Blk	May 2 40	41 YRS.			Jan 15 19 82				12:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York		U. S. A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Sil. Spring		Holy Cross Hosp.				Salesman			Private		
13a. STATE											
D. C.											
13b. CITY OR TOWN											
Washington											
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
13d. STREET ADDRESS											
1356 Iris Street, N. W.											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
Not Stated						Not Stated					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.			17. INFORMANT		
Yes						212-42-0103			Judith S. Andrews, Wife, 1356 Iris St., N.W.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Massive Subarachnoid Hemorrhage											
4300											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
None								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION			
								CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
John Rogers, M. D.				M.D. Dep				Jan 15, 1982			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
John Rogers, M. D.				1919 Seminary Road, Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				19 Jan 82		Mount Olivet Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
W. Ernest Jarvis Co., Inc., Washington, D. C.				JAN 25 1982				Name Jan			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 0 6 3			
1. DECEASED NAME (TYPE OR PRINT) <b>Elsie C. Apicella</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 8, 1982</b>				2b. HOUR <b>3:00 AM</b>	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 20 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		7b. IF UNDER 74 HRS. HOURS MIN. <b>MD</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15 De Sellum Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>secretary</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>15 De Sellum Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Matteo Apicella</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mariannina Capone</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no --</b>				16b. SOCIAL SECURITY NO. <b>018 05 2452A</b>		17. INFORMANT ADDRESS <b>Gaithersburg, Md. Maria C. Farrell 10022 Stedwick Rd. #203</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA</b> <b>1749</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE. CORONARY DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b> <b>1 YEAR</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 5, 1975</b> to <b>JANUARY 7, 1982</b> , that (I) (we) lost saw the deceased alive on <b>12/11/81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>[Signature]</i>				DEGREE				22c. DATE SIGNED <b>1/8/1982</b>			
22d. PHYSICIAN'S NAME (TYPE) <b>GREGORIO BASS MD</b>				22e. ADDRESS <b>13 E DEER PARK DR. GAITHERSBURG MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/11/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Milford, Massachusetts</b>					
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> 1331 Rockville Pike Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1982</b>					

REGISTRAR'S SIGNATURE



Jan. 6, 1965

Yokohama

C.

Alaska

79

25

20

10

White

Female

Montgomery

USA

Italy

retired secretary

15 De Solim Ave.

Geithersburg

15 De Solim Avenue

x

Montgomery Geithersburg

Maryland

Capone

Marxmanian

Apicalia

Matted

Geithersburg, Md.  
618 05 2452A

618 05 2452A

no

xx

St. Mary's Cemetery, Hildesheim, Niedersachsen

1/11/82

Burial

1931 Rockville Pike, Rockville, Maryland  
Tyson Wheeler Funeral Home, Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to examine the body.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1. STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Charles L APPEL					2a. DATE OF DEATH MONTH DAY YEAR 1 31 82 2b. HOUR M				
1. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. # 21 64	
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Glass Co.		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. STATE Maryland		13b. COUNTY Allegany		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 525 Columbia Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Appel					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Stuckenous				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W. 1					16b. SOCIAL SECURITY NO. 214-05-6509		17. INFORMANT Charles W. Appel, Derwood, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5355 IMMEDIATE CAUSE (a) <u>MASTRO-ENTEROLOGY Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>MASTROITIC</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>SPRINTING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>SPRINTING</u>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21e. LOCATION CITY OR TOWN COUNTY STATE					21f. LOCATION CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <u>1/31/82</u> to <u>1/31/82</u> that (I) (myself) saw the deceased alive on <u>1/31/82</u> and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above (or) (did) (did not) view the body (or) (did not) view the body (or) (did not) view the body (or) (did not) view the body									
22a. SIGNATURE Thos G. Ward					22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. Ward, 6116 Robin road, Bethesda Md 20817					22d. DATE SIGNED 2/1/82				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE Feb. 3, 82				
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Pk					23d. LOCATION CITY OR TOWN COUNTY STATE Cumberland Allegany Md.				
24. FUNERAL DIRECTOR NAME William G. Kight, Cumberland, Md.					25. DATE REC'D. BY REGISTRAR FEB 5 1982				

BP





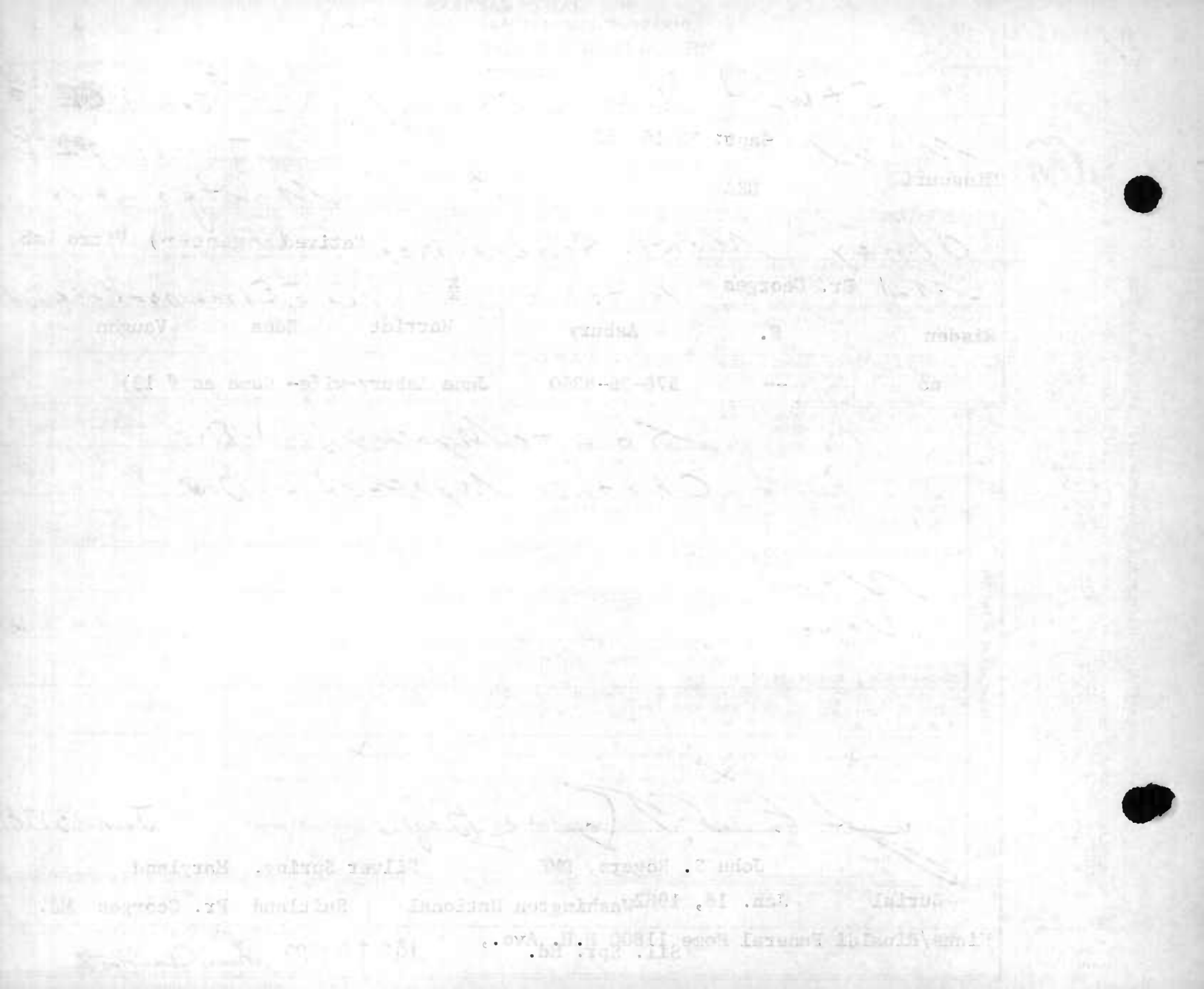


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR 15 ME (5))  
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02065	
1. DECEASED NAME (TYPE OR PRINT) <b>STUART M ASBURY</b> <i>Stuart M Asbury</i>							2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 13 1982</b> <i>Jan 13 1982</i>		2b. HOUR <b>3:45 PM</b> <i>3:45 PM</i>		
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YRS. <b>Sept: 30 16 65</b>		6. AGE (IN YEARS) MONTHS DAYS HOURS MIN. <b>16 5</b>		7c. DATE PRONOUNCED DEAD <b>Jan 13 1982</b>		7d. HOUR <b>3:45 PM</b>	
7a. BIRTHPLACE (STATE OR TERRITORY) <b>Missouri</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. General Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Vitro Lab</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md</b>		13b. COUNTY <b>Pr. Georges</b>		13c. CITY OR TOWN <b>Ritchie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1815 Elmwood Park Dr</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ridsen S. Asbury</b>						15. MOTHER'S MAIDEN NAME <b>Harriet Edna Vaughn</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				(IF YES, GIVE WAR OR DATES) <b>--</b>		16b. SOCIAL SECURITY NO. <b>578-36-8360</b>		17. INFORMANT ADDRESS <b>June Asbury-wife- Same as # 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chronic Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>						TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER		DATE SIGNED <b>Jan 13 1982</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>						ADDRESS <b>Silver Spring, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 18, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Georges Md.</b>			
24. FUNERAL HOME <b>Rinaldi Funeral Home</b>						ADDRESS <b>11800 N.H. Ave., Sil. Spr. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Phane Jan Norton</i>	



12.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST Harold Woodrow Atwood						MONTH DAY YEAR January 4, 1982		4 a.m.	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Caucasian		MONTH DAY YEAR April 29, 1912		69 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		1917 Rookwood Road								Section Chief Md. Natl Cap P&P	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? 13e. STREET ADDRESS											
Maryland Montgomery Silver Spring YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1917 Rookwood Road											
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William M. Atwood						Eva Lee Nicholson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				577-22-3594		Louise Frances Atwood Same as 13 Wife					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Uremia</u>										1 year	
4049 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <u>Hypertensive intracerebral hemorrhage</u>										10 years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetes mellitus</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>November 11, 1978</u> to <u>January 4, 1982</u> , that (I) (we) lost saw the deceased alive on <u>December 11, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>				DEGREE <u>M.D.</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Jan. 4, 1982</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Blaine H. Eitg, M.D.				9801 Georgia Avenue Silver Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		January 6, '82		St. Mary's Ceme.		Rockville Mont Md.					
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						JAN 8 1982		<u>[Signature]</u>			

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*[Faint, mostly illegible text and markings across the page, including what appears to be a signature and some numbers.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST <del>XXXXXXXXXX</del> <b>Jacqueline Jane Austin</b>					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-20-1982</b>					2b. HOUR <b>1:30 PM</b>									
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 15, 1965</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>16 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS <b>16</b>		IF UNDER 24 HRS. HOURS MIN. <b>16</b>		2c. DATE PRONOUNCED DEAD <b>Jan-20-1982</b>					2d. HOUR <b>1:30 PM</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D. C.</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>									
10. CITY OR TOWN OF DEATH <b>Bethesda</b>					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>13201 Brackley Road</b>												
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Austin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mable Respas</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>217-96-5141</b>					17. INFORMANT ADDRESS <b>James Austin, father, same address as above</b>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Injuries Severe</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Trauma Auto Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>8191</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9:40 am 1-20-1982</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Passenger in Car involved in Accident</b>														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>					21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1800 Blvd 7a Silver Spring Montgomery MD</b>														
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																								
ACTUAL SIGNATURE <b>John S. Bell</b>					TITLE (SPECIFY) <b>Deputy</b>					MEDICAL EXAMINER					DATE SIGNED <b>Jan 20, 1982</b>									
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>Jan. 23, 1982</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Maryland National</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel, Prince George, Maryland</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>McGuire Funeral Service, Inc., Washington, D. C.</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>					25b. REGISTRAR'S SIGNATURE <b>Thomas J. Nathan</b>									





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 6 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PATRICIA A. BAILEY			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1982			2b. HOUR 8:50PM M				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MONTGOMERY GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical		12b. HUSBAND'S NAME Hines/Rinaldi Funeral Home		
13a. STATE MARYLAND			13b. COUNTY MONTG.		13c. CITY OR TOWN SILVER SPG.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14820 Mistletoe Court	
14. FATHER'S NAME FIRST MIDDLE LAST KEITH R BOYLES			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Sweezlie			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None				
16b. SOCIAL SECURITY NO. 222 20 9332			17. INFORMANT ADDRESS Gerald Bailey (Husband) Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (1)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. Minarcik						DEGREE MD		22c. DATE SIGNED 1/5/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HECHT, M.D.						22e. ADDRESS 10620 Georgia Avenue Silver Spring, Md. 20902				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/7/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood PG Maryland			
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md						25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE James J. Hines		

MEDICAL CERTIFICATION

Released by Mont. Co. Med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2, and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1970 JAN 10 11 11 AM  
GALT 10 11 11 AM



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 0 6 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>EDNA C BANGHAM</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>19</b> YEAR <b>1982</b>				2b. HOUR <b>5:20 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>04</b> YEAR <b>1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISSOURI</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2006 Cascade Rd</b>	
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>G.</b> LAST <b>Squires</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Minnie</b> MIDDLE <b>Annette</b> LAST <b>Sisson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>374-10-1443</b>		17. INFORMANT <b>Barbara A. Duvall Burtonsville</b> ADDRESS <b>14605 Dowling Drive</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4321</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Subdural Hematoma</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Stroke Syndrome</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MINS</b> <b>34 days</b> <b>34 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Coronary Artery Disease</b>											
19. DATE OF OPERATION <b>1/6/82</b>				19a. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subdural Hematoma</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <b>12/10/81</b> , 19____, to <b>1/19/82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/19/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Richard Croff</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/19/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Croff</b>				22e. ADDRESS <b>10620 Georgia Ave. Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>January 23, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> <b>Homes, P.A. Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner's inquest held.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Giovanni Mario BARBERO						2a. DATE OF DEATH MONTH DAY YEAR JAN 10 82		2b. HOUR MIN. 3 35 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov. 25, 1897		6. AGE (IN YEARS, LAST BIRTHDAY) YRS. 84		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY Italy		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD				
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1608 Blue Meadow Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Giuseppe Barbero			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Delu							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS Fernando J. Barbero same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2019 IMMEDIATE CAUSE (a) HODGKINS DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the undersigned) attended the deceased from 4 JAN 19 82 to 10 JAN 19 82, that (I) (we) last saw the deceased alive on 5 JAN 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE Walter E. Goetz MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10 JAN 82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/13/1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.				24. ADDRESS Rockville, Maryland		25a. DATE REC'D BY REGISTRAR JAN 12 1982				



NOTED

HOPE KIM - WIFE OF

CO. 2ND INF. 1ST DIV.

UNITED STATES ARMY

UNITED STATES ARMY

72

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 0 7 1	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM A.M. BARTZ</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>17</b> DAY <b>17</b> YEAR <b>1982</b> 2b. HOUR <b>4:30A</b>	
3. SEX <b>MALE</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>19</b> YEAR <b>15</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>66</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD <b>Jan 17 1982</b> 2d. HOUR <b>4:30A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Manufacture</b>	
USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12516 VOERS RD # 103</b>			
14. FATHER'S NAME FIRST <b>Arthur</b> MIDDLE <b>H.</b> LAST <b>Bartz</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Tekla</b> MIDDLE <b>Schade</b> LAST <b>Schade</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Elda O. Bartz-Same as items 13a-e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John S. Rogers</b>						TITLE (SPECIFY) <b>M.D. Dep.</b> MEDICAL EXAMINER			DATE SIGNED <b>Jan 17/1982</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>						ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>1/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>				23d. LOCATION CITY OR TOWN <b>Alexandria</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>											





1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Belle R. Beaman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1982</b>			2b. HOUR <b>11:10<sup>AM</sup></b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 18, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>				
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1411 Ballard Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Nelson H. Robertson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary R. Ricketts</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>Not Avail.</b>		17. INFORMANT <b>Sister</b> ADDRESS <b>Mrs. Paul M. Lehman Same as item 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b></b>										
19a. DATE OF OPERATION <b>1/11/82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b></b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <b></b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>1965</b> to <b>1/11/82</b> , that (I) (we) last saw the deceased alive on <b>1/11/82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not used, I did not view the body after death.)										
22b. SIGNATURE <b>Henry C. Scruggs, M.D.</b>			22c. ADDRESS <b>5413 Cedar Lane Bethesda, Maryland</b>			22d. DATE SIGNED <b>January 11, 1982</b>		22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 14, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery Washington, D.C.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b>					
25b. REGISTRAR'S SIGNATURE <b>James Van Natta</b>										

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.



1945

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #1 Film G563 2/17/82 rc										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 2 0 7 3									
1- STATE REGISTRAR										CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <u>Amanda</u>										2a. DATE OF DEATH MONTH DAY YEAR <u>Jan. 13, 1982</u>										2b. HOUR <u>1:20</u> P.M.									
3. SEX <u>Female</u>										4. RACE <u>White</u>										5. DATE OF BIRTH MONTH DAY YEAR <u>Nov. 25 1896</u>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Isle Lamotte, Vt.</u>										7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>										6. AGE (IN YEARS LAST BIRTHDAY) <u>85</u> YRS.									
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>8811 Colesville Road</u>										9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.									
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Md.</u> 13b. COUNTY <u>Mont.</u> 13c. CITY OR TOWN <u>Sil. Spr.</u>										12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>										12c. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>									
14. FATHER'S NAME FIRST MIDDLE LAST <u>Arthur H. Hill</u>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Kathleen Simon</u>										13d. INSIDE CITY LIMITS? YES <u>xx</u> NO <input type="checkbox"/>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>										16b. SOCIAL SECURITY NO. <u>098-10-7637</u>										17. INFORMANT ADDRESS <u>9727 Mt. Pisgah Rd. Silver Spring, Md.</u>									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis Heart Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21 months</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4140</u>										DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis generalized</u>										<u>5 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>none</u>																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										21f. LOCATION CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 19 <u>75</u> , to <u>January 13</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan 12</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <u>Ralph R. Patten</u>										DEGREE <u>M.D.</u>										22c. DATE SIGNED <u>1-14-82</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ralph R. Patten, M.D.</u>										22e. ADDRESS <u>1407 Woodside Parkway, Sil. Spr., Md.</u>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>										23b. DATE <u>1/14/82</u>										23c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Crematory Alexandria, Md.</u>									
24. FUNERAL DIRECTOR NAME <u>Warner E. Pumphrey, Inc.</u>										25a. DATE REC'D BY REGISTRAR <u>JAN 20 1982</u>										25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>									



x



JAN 30 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

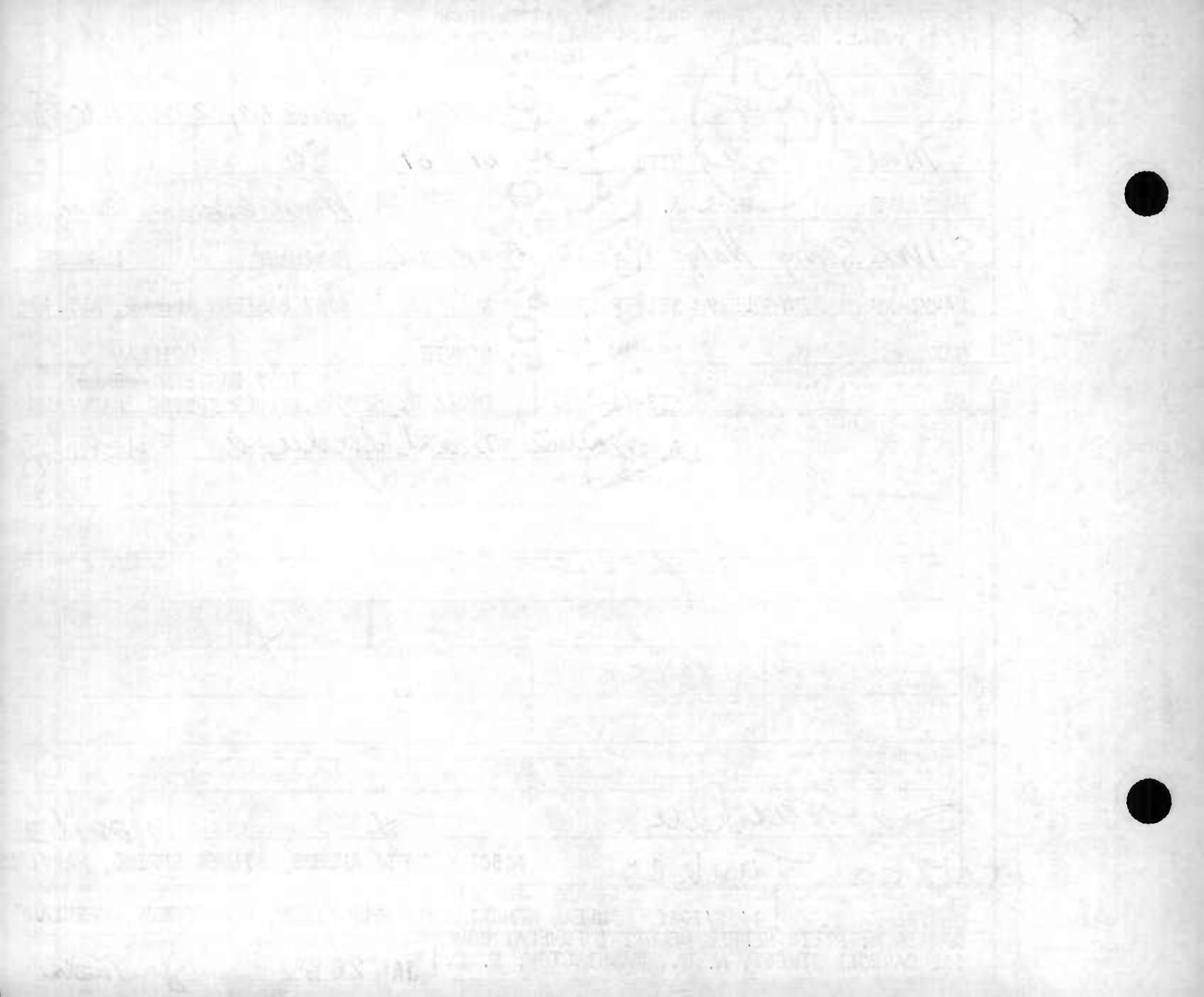
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Items #13&17 per phone call  
 1- STATE REGISTRAR  
 w/Fun. Home 2/17/82rc  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 2 0 2 0 7 4

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>ALBERT</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 20, '82</b>			2b HOUR <b>10<sup>25</sup> M</b>			
3 SEX <b>Male</b>		4 RACE <b>W HITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>3 01 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		12b KIND OF BUSINESS OR INDUSTRY <b>LUGGAGE</b>	
13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>SILVER SPRING</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>8007 EASTERN AVENUE, Drive</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>MAX</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINNIE GOLDMAN</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES) <b>NO</b>					
16b SOCIAL SECURITY NO. <b>578-10-4433</b>		17 INFORMANT <b>PAULA B. BERMAN, SILVER SPRING, MARYLAND</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>congestive heart failure</b> <b>4280</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DOE TO, OR AS A CONSEQUENCE OF (b) _____ DOE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Isa Taubler</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED <b>1/20/82</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Isa Taubler</b>				22e ADDRESS <b>10301 GEORGIA AVENUE, SILVER SPRING, MARYLAND</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>1/22/1982</b>		23c NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS OLNEY, MONTGOMERY, MARYLAND</b>				23d LOCATION	
24 FUNERAL HOME <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		25b REGISTRAR'S SIGNATURE <b>James Jan Nathan</b>			
26 ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>									

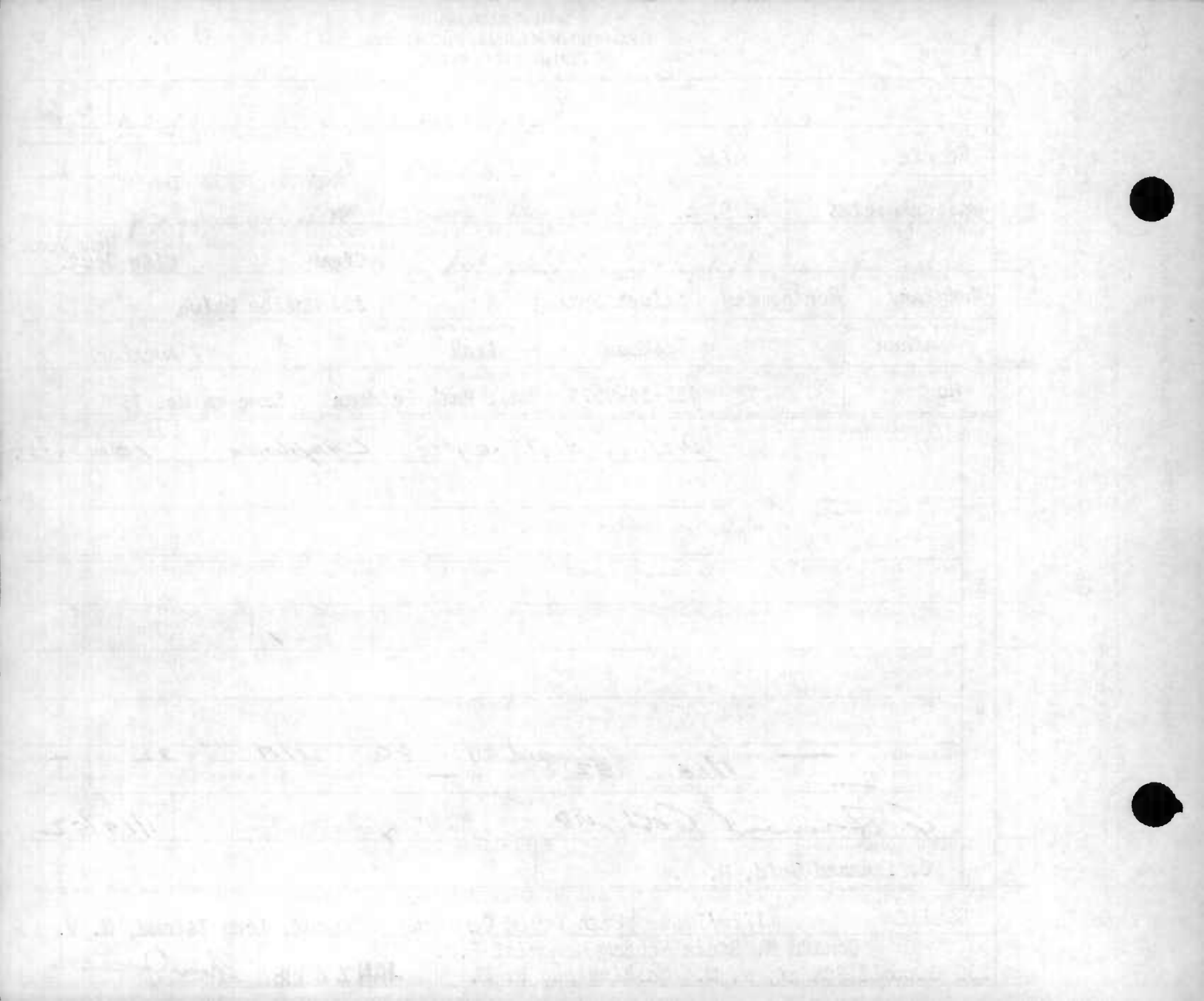


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 0 7 5			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) Sarah Bernstein					2a. DATE OF DEATH MONTH DAY YEAR 1-19-82				2b. HOUR 3:15 M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-05-07		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY New York City Govt.				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 824 Malibu Drive			
14. FATHER'S NAME Nathan				MIDDLE Fishman		15. MOTHER'S MAIDEN NAME Leah				MIDDLE Averbach			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 055-30-9573		17. INFORMANT Mrs. Ruth Feldman				ADDRESS Same as No. 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse Histiocytic Lymphoma 2000 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from August 29, 19 80, to 1/19, 19 82, that (I) (we) lost saw the deceased alive on 1/16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE C. Lennard Gold, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/19/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Lennard Gold, M. D.						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 1/20/1982		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Elmont, Long Island, N. Y.				
24. FUNERAL DIRECTOR NAME Donald M. Stein Hebrew Memorial F.H.						25a. DATE REC'D. BY REGISTRAR JAN 22 1982		25b. REGISTRAR'S SIGNATURE [Signature]					
232 Carroll Street, N. W. Washington, D. C.													





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
CHARLES MARVIN BLACKBURN								1-21-82		19		M	
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		8. HOUR	
male	white	NOV 25, 1923		58 YRS.						1-21-82		19 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		XX NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
ALABAMA		U.S.A.		WIDOWED		DIVORCED		Montgomery County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		15320 Layhill Road		ENGINEER		JOHN HOPKINS APL							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		WHEATON		YES X NO		2713 WELLER ROAD					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
JOHN BLACKBURN		IDA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
YES		WW II		507-18-6989		RITA A. BLACKBURN		SAME AS 13		WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Multiple chest injuries													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES X NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
XX				8:25AM 1-21-82				driver of auto lost control and impacted another vehicle					
21d. INJURY OCCURRED WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. CITY OR TOWN					
NOT WHILE AT WORK				street				15320 Layhill Rd. Silver Spring, Maryland					
22a. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry, and in my opinion death resulted from Natural causes, Accident XX, Suicide, Homicide, Undetermined manner.													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				Assistant				1-22-82					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Margarita A. Korell, M.D.				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
BURIAL				1/25/82				GATE OF HEAVEN				SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS				JAN 27 1982				Francis J. Nathan					
500 UNIV. BLVD., W. SILVER SPRING, MD. 20901													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 0 7 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Rose Mary O'Mara Blair</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1982</b>		2b. HOUR <b>2:30A M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 24, 1884</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) MONTHS DAYS HOURS MIN. <b>97 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4412 Ambler Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>4412 Ambler Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. O'Mara</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose M. Cusick</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>no</b>		16b. SOCIAL SECURITY NO. <b>090-07-3942</b>		17. INFORMANT ADDRESS <b>Son-Lewis R. Blair-12300 Old Canal Rd. Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>4349</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Coronal Infarctions</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 2, 1981</b> to <b>Jan 11, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Jan 11, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN <b>E. Stuart Lyddane</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 12, 1982</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 13, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Mont., Md.</b>				24. FUNERAL DIRECTOR NAME ADDRESS <b>DeVol Funeral Home Washington, D.C.</b>			
25. DATE RECEIVED BY REGISTRAR <b>JAN 18 1982</b>				26. SIGNATURE OF REGISTRAR			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Medical Examiner, Dr. Ball, Notified and approved.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 7 8

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charlotte Bloch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01-10-82</b>			2b. HOUR <b>11:07 P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 1 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b>		7. IF UNDER 1 YEAR MONTHS DAYS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria-Hungary</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Beth. Nursing &amp; Ret. Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>			13b. COUNTY <b>None</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3701 Conn. Ave. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Baruch Schrottman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julie Toff</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>093-12-7220 D</b>		17. INFORMANT ADDRESS <b>Lawrence J. Bloch Same as item # 13</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular disease</b> <b>4379</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>S/p Hip Fracture</b>									
19a. DATE OF OPERATION <b>1/13/82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>S/p Hip Fracture</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 10 1982</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>1145 15th St. N.W. WASH D.C.</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/13/82</b> to <b>1/10/82</b> , that (I) (we) last saw the deceased alive on <b>1/13/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Morton Kavalier</b>						DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morton Kavalier</b>						22e. ADDRESS <b>1145 15th St. N.W. WASH D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Mt. Carmel Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn, N.Y.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>						25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <b>JAN 18 1982</b>			

No.

Baron

Seibert

Julia

Toll

D.C. Home

Washington

X

2701 Conn. Ave. N.W.

Gray, Charles

beta. Murray & Sec. Inter.

Homestead

Home

Walter-Burnett

US

1/1/85

1/1/85  
New A.C. Central Com.  
Brooklyn, N.Y.  
1/1/85

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										8 2 0 2 0 7 9	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH			2b. HOUR		P	
ALEASE (NMN) BOGLE					January 26, 1982			7:35		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		Negro		November 13, 1913		68		YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Clinical Center, NIH, Beth., Md				Housewife		Own Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Virginia		S. Hampton		Boykins		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		General Delivery 23827			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
Tom (nmn) Barham					Mary (nmn) Madry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.		17. INFORMANT				
No					None		Mr. Woodrow Bogle (husband)				
					224-03-4046		1121 Hampton Ave, Newport News, Va 23607				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Bronchopneumonia										2 weeks	
2028											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Lymphoma										2 years	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
Hypogammaglobulinemia, Fungal osteomyelitis											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
			HOUR A.M. MONTH DAY YEAR		P.M.		19				
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 11, 1982, to January 26, 1982, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 26, 1982, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE					DEGREE			22c. DATE SIGNED			
John J. O'Shea Jr.					MD			1-27-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
JOHN J. O'SHEA JR. MD					National Institutes of Health Clinical Center, Bethesda, Md 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			1-30-1982		so. View Cemetery		Franklin, so. Hampton, Va				
24. FUNERAL DIRECTOR											
W.W. Chambers Co Inc											
8655 Georgia Ave, Sil Spg, Md											



NOTED ON THE 10th

10th

10th

10th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

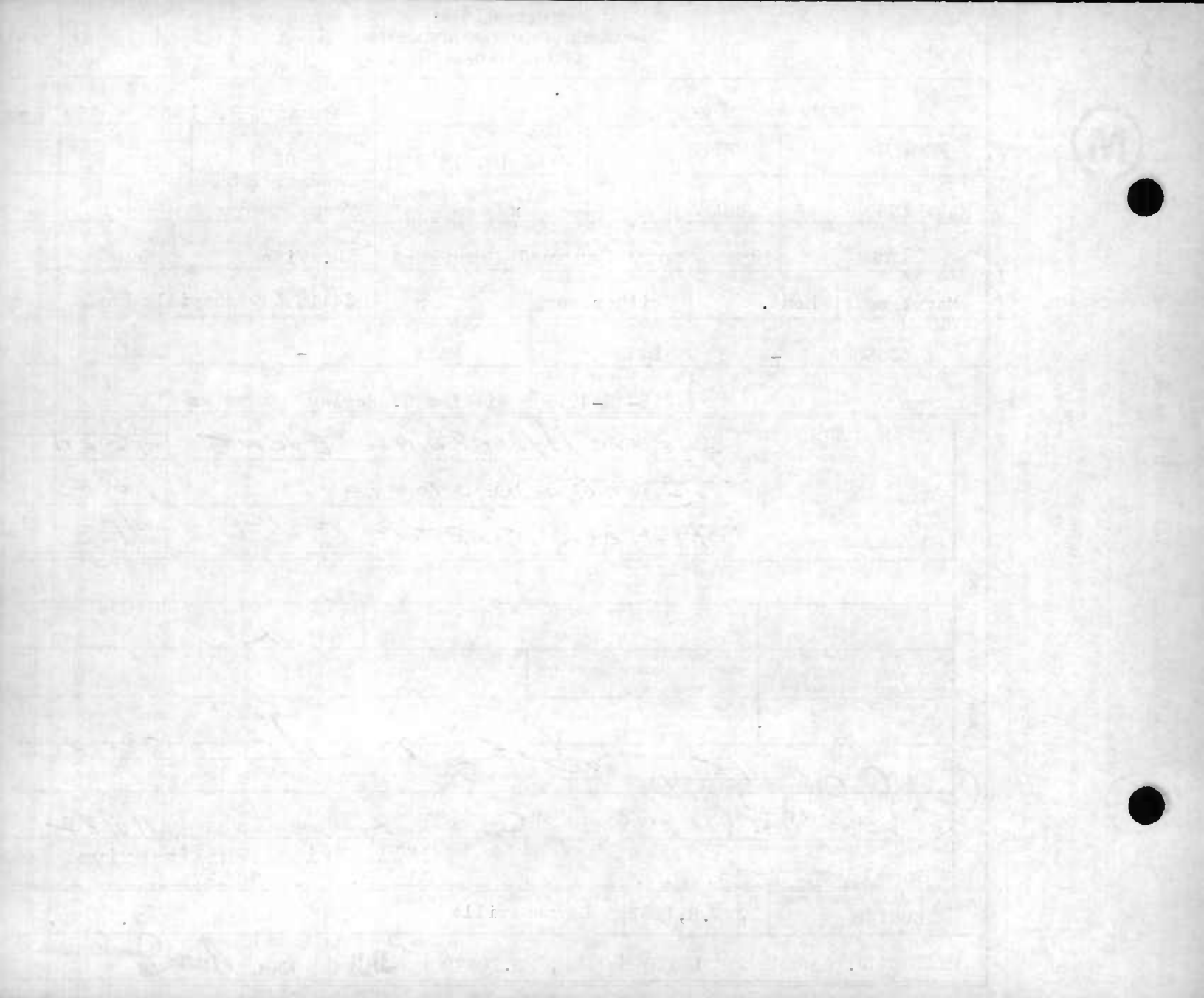
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH				2b. HOUR			
		Mary FRANCINE Bogley						January 5, 1982				10:20am			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.	
FEMALE		WHITE		JULY 10, 1899				82 YRS.				MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
MARYLAND		USA						Montgomery County, MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital						H. Wife				Home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Mont.		Gaithersburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24118 Laytonsville Road							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
JOSHUA - RIGGS				MARY - BEALL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
no				215-46-4317				William R. Bogley				Same as #13			
18. CAUSE OF DEATH (Enter only one cause and code for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE: <u>Acute Myocardial Event</u>										TERM.					
4100															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										1 WK					
DUE TO, OR AS CONSEQUENCE OF: (b) <u>BRONCHOPNEUMONIA</u>															
DUE TO, OR AS CONSEQUENCE OF: (c) <u>ARTERIOSCLEROTIC C.V.D.</u>										YES.					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE							
22. I certify that (1) (this hospital) attended the deceased from 4/5 1980 to 1/5 1982, that (1) (we) lost the deceased alive on 1/5 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated.															
22a. SIGNATURE				DEGREE				22c. DATE SIGNED							
Donald R. Lewis, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1/5/82							
22a. PHYSICIAN'S NAME (TYPE OR PRINT)				22b. ADDRESS											
				18111 Prince Philip Drive											
				Olney, Md. 20832											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				JAN. 8, 1982		Laytonsville				LAYTONSVILLE					
										COUNTY MONT. STATE MD.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
FRANCIS H. BARBER				LAYTONSVILLE, MD. 20879				JAN 8 1982							

MEDICAL CERTIFICATION

29

0100  
BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G565 3/16/82 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 02081		
1. DECEASED NAME (TYPE OR PRINT) <b>Norma P. Bonita</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>XX 1 13 19 82</b>		2b. HOUR P. M. <b>M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 3, 1944</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>37</b> YRS.		7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>US</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13515 Georgie Ave., Apt. 202</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEMPO Agency</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13515 Georgia Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edwin Kaler</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Norma Frye</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-42-2945</b>			17. INFORMANT ADDRESS <b>Norma Kaler 1800 Old Meadow Rd. 22102 McLean, Va.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Amitriptyline Intoxication</b> <b>9503</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Est. 1/13/82</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Ingested drug</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>13515 Georgie Ave. Apt. 202 Silver Spring Montg. Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1-17-82</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>				ADDRESS <b>111 Penn Street</b>								
23a. BURIAL CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1/18/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>						25. DATE REC'D. BY REGISTRAR <b>1/24/82</b>						
ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>						REGISTRAR'S SIGNATURE <b>Ph...</b>						

XX

22

244

1920

1335 Georgia Ave.

3.

NOTES

72000000

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1172

1992-1993

2142

• 2000

NOTES FOR THE RECORD

550-45-5042

24

• 50% , 60% , 70%

170700015

Order 1111

показано

1. The first part of the document is a list of names and addresses, which appears to be a directory or a list of contacts. The names are written in a cursive script, and the addresses are listed below them. The list includes names such as "John A. Smith", "Mary E. Jones", and "Robert L. Brown".

52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 is not, injury, or other traumatic event, the medical examiner must be notified of this.

Cleared by Dr. John G. Ball

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 0 8 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) <b>Lillian Aline Bert</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 1 1982</b>				2b. HOUR <b>12:18AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 7 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE COUNTRY STATE OR FOREIGN <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) <b>5109 Danbury Road</b>				12a. USUAL OCCUPATION (IF WORKING FOR A BUSINESS OR INDUSTRY, GIVE WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>Maryland Montgomery Bethesda</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>5109 Danbury Road</b>									
14. FATHER'S NAME FIRST MIDDLE <b>Edward W. Phillips</b>				15. MOTHER'S MAIDEN NAME MIDDLE <b>Pinkey L. Pleasants</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>213 50 2732</b>		17. INFORMANT ADDRESS <b>Rev. William L. Bert Same as item 13 a-e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>10 yr.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) <del>the hospital</del> attended the deceased from <u>1975</u> to <u>1/1</u> , 19 <u>82</u> , that (1) <del>(we)</del> lost saw the deceased alive on <u>12/31</u> , 19 <u>81</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>(we)</del> <del>(did)</del> (did not) view the body after death.													
22b. SIGNATURE <b>Lewis N. Cahill</b>						DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-2-82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis N. Cahill</b>						22e. ADDRESS <b>5411 Cedar Lane Bethesda, Maryland 20014</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-5-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Widwood Church Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY <b>Bethesda Mont. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
24. FUNERAL DIRECTOR ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>													

FILED • U. S. DEPT. OF JUSTICE

1321 Rockville Pike Rockville, Md. 20852  
Tyson Wheeler Funeral Home, Inc.

Burial 1-5-82 Midwood Church Cem. Bethesda Mont. Maryland

Lewis H. Cahill 2411 Cedar Lane Bethesda, Maryland 20814

1-5-81

No - - - 215 50 2732 Rev. William L. Hunt Same as item 15 a-o

Edward W. Phillips Pinkney L. Flanagan

Maryland Montgomery Bethesda K 2109 Garbary Road

Bethesda 2109 Garbary Road Housewife Home

Marh. U.O. U.S.A. K Montgomery

Female White 7 7 1892 82

William Alene Hunt

1 1 1982 12:18AM

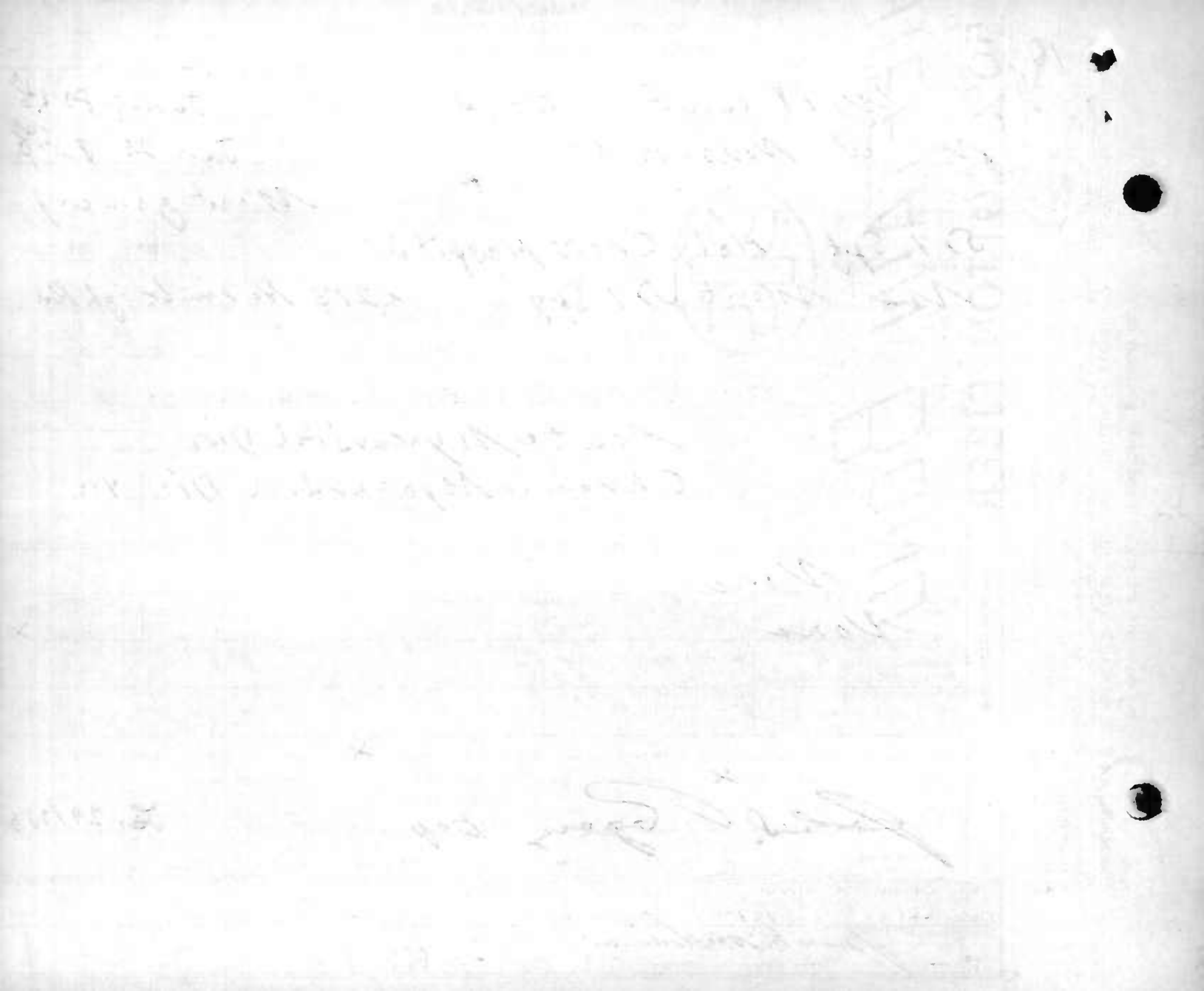


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William F. Boyd</b>		2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 29 1982</b>		2b. HOUR <b>PM 8:00</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 20 14 67</b> YRS.	6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>14 67</b>	7. DATE PRONOUNCED DEAD <b>Jan 29 1982</b>	7b. HOUR <b>PM 8:00</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Sgt. Sp5</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>	
13c. CITY OR TOWN <b>Sgt. Sp5</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2213 Hermleigh Rd</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry J. Boyd</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Prehoda</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>522-14-5595</b>		17. INFORMANT <b>Barbara L. Boyd</b>		ADDRESS <b>Same as 13e.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>4291</b> (b) <b>Chronic Myocardial Dis</b> yrs. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER <b>John S. Rogers</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers DME</b>		ADDRESS <b>Silver Spring, Maryland</b>		DATE, SIGNATURE <b>Jan 29 1982</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>2/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Shane Dan Northon</b>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITALS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02084											
1. DECEASED NAME (TYPE OR PRINT)					FIRST Ronni					MIDDLE Karen					LAST Braverman					2a. DATE OF DEATH		KNOWN ESTIMATED		MONTH 1		DAY 25		YEAR 1982		2b. HOUR 9 <sup>00</sup> PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jun 1, 1943		6. AGE (IN YEARS) (LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR Jan 25, 1982		2d. HOUR 9 <sup>00</sup> PM															
7a. BIRTHPLACE (STATE OR COUNTY) Phila., Pa.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD																			
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13837 Dowlais Drive								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Caterer				12b. KIND OF BUSINESS OR INDUSTRY Catering															
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Rockville				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 13837 Dowlais Drive																	
14. FATHER'S NAME FIRST MIDDLE LAST Harry F. Saltz								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Klatzkin																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None				17. INFORMANT Thomas G. Brubaker				ADDRESS 13837 Dowlais Dr. Rockville Md 20850																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas with Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE John A. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED Jan 26, 1982																			
EXAMINER'S NAME (TYPE OR PRINT) JOHN G. BALL, M.D.				ADDRESS 7936 Old Georgetown Rd. Bethesda, Md																											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Jan 26, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Dr. George Md																					
24. FUNERAL DIRECTOR W.W. Chambers Co Inc				ADDRESS 8655 Georgia Ave Silver Spring, Md				25a. DATE OF BURIAL JAN 26 1982				25b. NAME OF BURIAL HOME Harris																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 494-9449.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>Edith N. Edith Brazeal</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 82</b>					
3. SEX <b>Female</b>		4 RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 24 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7b. HOUR <b>7:15 AM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>H. Wilson Health Care Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		
13a. STATE <b>Georgia</b>					13b. COUNTY <b>Fulton</b>		13c. CITY OR TOWN <b>East Point</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Judson - North</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret J. Conley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -</b>					16b. SOCIAL SECURITY NO. <b>255-03-3317D</b>		17. INFORMANT ADDRESS <b>William W. Brazeal 4716 Bartram St. Rockville, Md. 20853</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4340</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>4 mo.</b> <b>10 yrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>Congestive heart failure, Urinary tract infection</b>										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>July 19 81</b> to <b>Jan 27 19 82</b> , that (1) (we) lost saw the deceased alive on <b>Jan 19 19 82</b> , and that in my (a) (ur) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James R. Moore Jr.</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1-27-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr.</b>					22e. ADDRESS <b>207 Brookes Ave Gaithersburg Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Atlanta Fulton Ga.</b>		24. FUNERAL DIRECTOR <b>Gartner Sandison F. H. Gaithersburg, Md. 20877</b>		
25. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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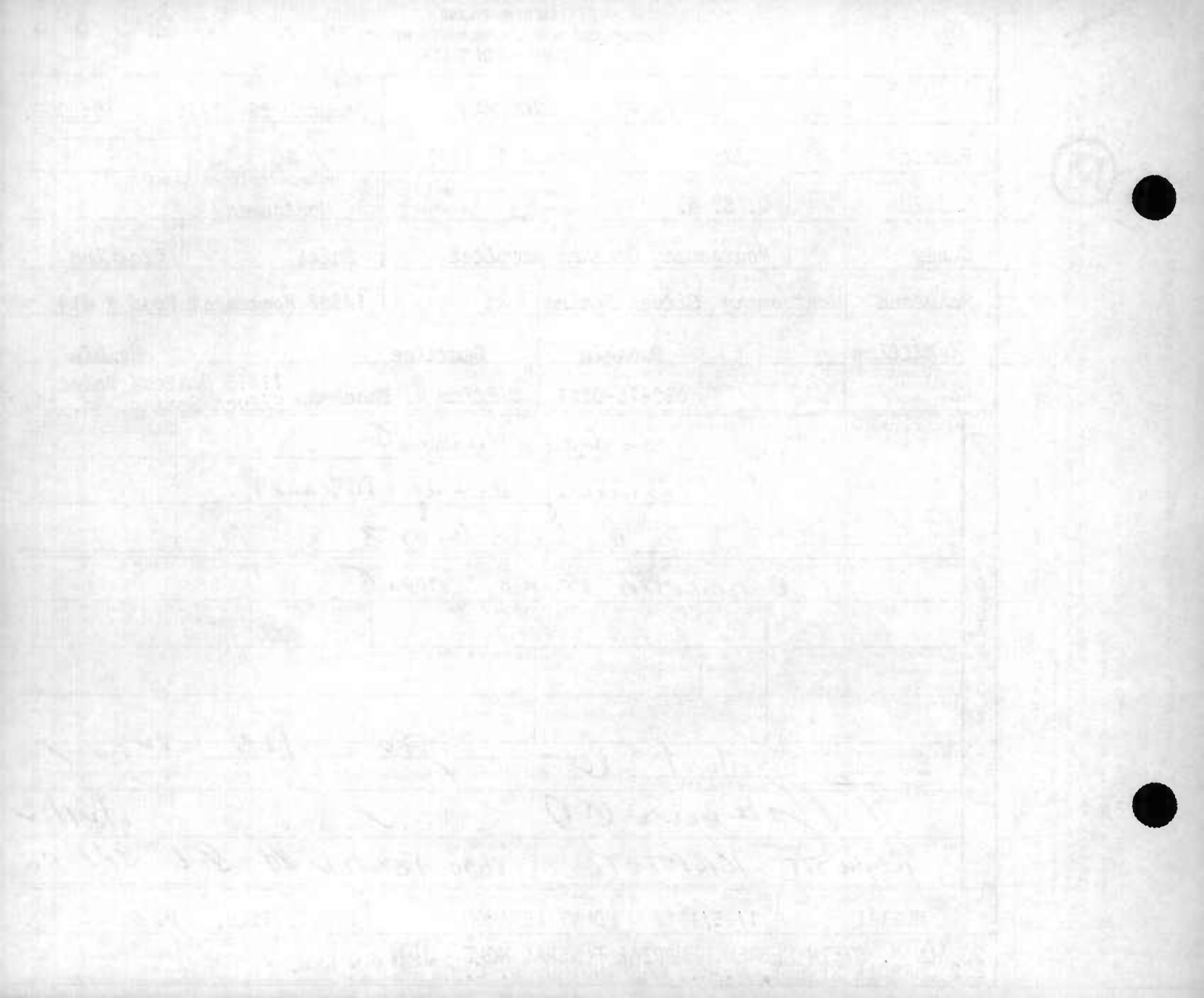
1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA BROCKMAN			2a. DATE OF DEATH MONTH DAY YEAR January 23, 1982		2b. HOUR 9:00 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 1, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales	12b. KIND OF BUSINESS OR INDUSTRY Clothing	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 14508 Homecrest Road # 414
14. FATHER'S NAME FIRST MIDDLE LAST William Dworkin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Henkin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 062-16-0281		17. INFORMANT ADDRESS William R. Brockman 11215 Oakleaf Drive, Silver Spring, Md. 20901	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary artery Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerosis</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of the Breast</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>72</u> to <u>1/23</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/23/</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>R. Kramer MD</u> DEGREE				22c. DATE SIGNED 1/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT KRATIER				22e. ADDRESS 8630 FENTON ST S.E. S.F. MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/25/1982	23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON		23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE, P. G. MD.
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR JAN 28 1982	

REGISTRAR'S SIGNATURE





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02087	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Edwin P. Brodnax</b>										2a. DATE OF DEATH <b>Jan. 7 1982</b>	
3. SEX <b>Male</b> 4. RACE <b>White</b> 5. DATE OF BIRTH <b>May 7 1920</b> 6. AGE (IN YEARS) <b>61</b> 7. IF UNDER 1 YR. <b>MONTHS</b> <b>DAYS</b> <b>HOURS</b> <b>MIN.</b> 8. IF UNDER 24 HRS. <b>MONTHS</b> <b>DAYS</b> <b>HOURS</b> <b>MIN.</b>										2b. DATE OF DEATH <b>Jan. 7 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ark.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8105 Beech Tree Rd.</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Systems Analyst of Defense</b>	
13a. STATE <b>Md.</b> 13b. CITY OR TOWN <b>Mont.</b> 13c. CITY OR TOWN <b>Bethesda</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>8105 Beech Tree Road</b>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>Eugene Brodnax</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Una Westbrook</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> 16b. SOCIAL SECURITY NO. <b>429-20-4533</b> 17. INFORMANT <b>William Buckley, Jr.</b> ADDRESS <b>Silver Spring Md. 920 North West Dr.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CardioVascular Disease -</b> <b>4149</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary Artery Disease -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Alcoholism.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Alcoholism.</b>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John G. Ball</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER										DATE SIGNED <b>Jan 7 1982</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b> ADDRESS <b>7936 Old Georgetown Rd. Beth., Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> 23b. DATE <b>1/8 /1982</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland.</b>											
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James Van Natta</b>	

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

• **Interpretation:** **Snailfish!**

FORM-OS-24A (Rev. 3-11-54) 202

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BERT FRANKLIN BROWN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 20, 1982		2b. HOUR 6:43 a.m.
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 3, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UTAH	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (WORK OR NON-WORKING LIFE) Ret. Rear Admiral		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN KENSINGTON	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9631 HAWICK LANE KENSINGTON, MARYLAND 20798	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES FRANKLIN BROWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA MAY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1926-1955 011-30-6948		17. INFORMANT 7800 CHAPMAN ROAD ELIZABETH MURPHY: KINGSVILLE, MD. 21087	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST

4275  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) DUE TO, OR AS A CONSEQUENCE OF

(c) DUE TO, OR AS A CONSEQUENCE OF

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 20 JANUARY 19 82 to 20 JANUARY 19 82, that (I) (we) last saw the deceased alive on 20 JANUARY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.			
22b. SIGNATURE E.M. Lynch MD. LMCUSNR MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 21 JAN 82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E.M. LYNCH, LT. MC, USNR		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 25, 1982	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery, Arlington, VA.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 26 1982	
		25b. REGISTRAR'S SIGNATURE Charles Van Nuthen	



101

Handwritten text, possibly a date or reference number, oriented vertically.



Vertical text, possibly a date or reference number, oriented vertically.

Handwritten text at the bottom center, possibly a signature or date.

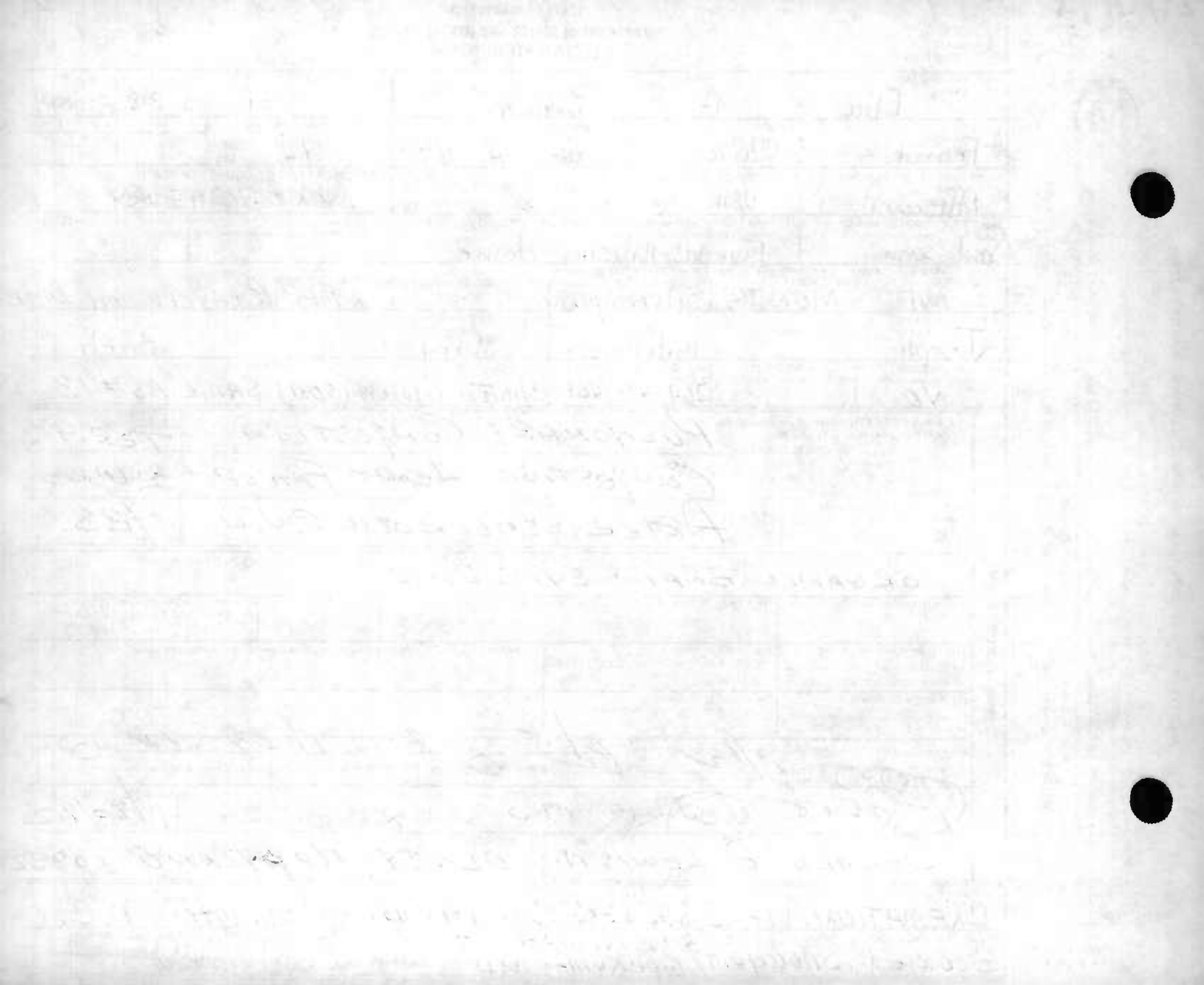
Handwritten text at the bottom left, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
Ella H. Brown			01 23 82			8:00 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		Cauc.		06 24 87		94 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Missouri		USA				MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Sandy Spring		Friends Nursing Home								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD			MONTG.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		2913 Beaverwood Lane	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
Joseph Hutchason			Mary Birch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO			264-41-9401		Clinton Brown (SON) Same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									TERMINAL	
IMMEDIATE CAUSE (a):									2 WKS	
4392 DUE TO, OR AS A CONSEQUENCE OF: (b) PULMONARY CONGESTION										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:										
DUE TO, OR AS A CONSEQUENCE OF: (c) COMPETITIVE HEART FAILURE										
ARTERIO-SCLEROTIC C.V.D.									YES.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):										
ORGANIC BRAIN SYNDROME.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 1/12/82 to 1/23/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated										
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
Donald R. Lewis MD			MD						1/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
DONALD R. LEWIS MD			OLNEY, MARYLAND 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
CREMATION			1-25-82		Lee's Crematorium		WASHINGTON D.C.			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
George P. Snowden			246 N. WASH. ST. ROCKVILLE, MD			JAN 20 1982				





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IN ADVANCE. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY. IF THE DEATH IS SUSPECTED TO BE SUICIDE, HOMICIDE, OR OTHERWISE UNNATURAL, THE MEDICAL EXAMINER SHOULD BE NOTIFIED IMMEDIATELY.

DHMH-17  
(VR A) 5 ME (5)  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02090	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ray H. Brown										2b. HOUR 10:49P	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3 14 09		6. AGE (IN YEARS LAST BIRTHDAY) 27 YRS.		7. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 7 1982		2d. HOUR 10:49P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ladara Unknown				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) cab driver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-24-6867		17. INFORMANT ADDRESS Thelma B. Brown 6412 Hopi Street Little Rock, Ark.				12b. KIND OF BUSINESS OR INDUSTRY Yellow Cab	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE John S. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED Jan 7, 1982			
EXAMINER'S NAME (TYPE OR PRINT) John S. Ball, DME				ADDRESS Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 1/11/82				23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.				ADDRESS P.O. Box 7428 Sil. Spr., Md.				23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Va.			
25a. DATE REC'D. BY REGISTRAR (REGISTRAR'S SIGNATURE) JAN 18 1982											

MEDICAL CERTIFICATION



BOOK COLLECTION 1910

THE UNIVERSITY OF CHICAGO



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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR			8 2 0 2 0 9 1		
1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTINE CATHERINE BUCCA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 16 1982</b>		2b. HOUR P <b>2140 P</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH <b>OCTOBER 12 1914</b>	6. AGE (IN YEARS, LAST BIRTHDAY) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN) <b>WASHINGTON DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MARKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR IND <b>Home</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. MARYLAND 13b. <b>Montgomery</b> 13c. <b>POTOMAC</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>WILLIAM EDWARD THOMAS</b> LAST		15. MOTHER'S MAIDEN NAME <b>JOSEPHINE</b> MIDDLE <b>DUFF</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>578 32 8358</b>		17. INFORMANT ADDRESS <b>RALPH E BUCCA 8706 BUNNELL DRIVE POTOMAC M.D.</b>	
18. CAUSE OF DEATH (Enter only one cause of death.) <b>WIDELY DISSEMINATED INFILTRATIVE DUCT CARCINOMA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>10 JANUARY 82</b> , to <b>16 JANUARY 82</b> , that (I) (we) lost saw the deceased alive on <b>16 JANUARY 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>B.E. CARLSON</b>		DEGREE		22c. DATE SIGNED <b>16 JANUARY 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.E. CARLSON</b>		22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Jan 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>	
23d. LOCATION <b>Silver Spring, Maryland</b> STATE		24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> NAME <b>Homes, P.A. Bethesda, Maryland</b> ADDRESS			
25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James S. Nathan</b>			

100-100000-10000



COLLECTION



SPR 88 146

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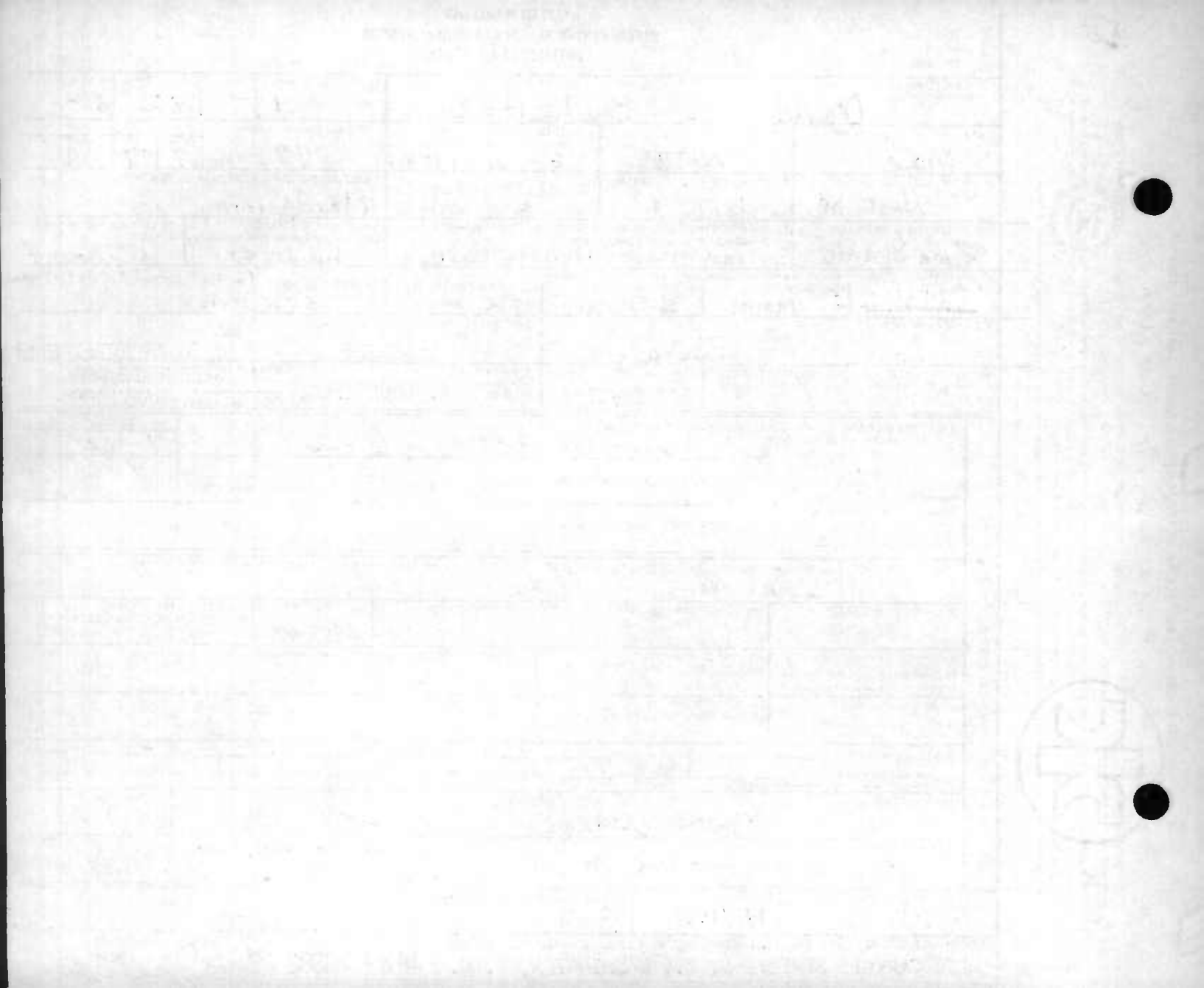
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David c. Buchalter					2a. DATE OF DEATH MONTH DAY YEAR 1 7 82		2b. HOUR 5 <sup>10</sup> a. M.		
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 21 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. DC.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Mont. 13c. CITY OR TOWN S.S. md.					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1220 East/West High S.S. md.		
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Buchalter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE (UNASCERTAINABLE)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 578-26-2798		17. INFORMANT ADDRESS ROBERT A. BUCHALTER, 7816 GREENTWIG ROAD, BETHESDA, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 4370 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes mellitus									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 19 81, to 1-7-82, that (I) (we) lost saw the deceased alive on 12-2-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jason Geiger M.D.					DEGREE		22c. DATE SIGNED 1-7-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER, M.D.					22e. ADDRESS 5830 CAMERON STREET SILVER SPRING, MD. 20910				
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 1/8/1982		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON HEBREW CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C.		
24. FUNERAL HOME STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 11 1982 Frances Van Notten			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

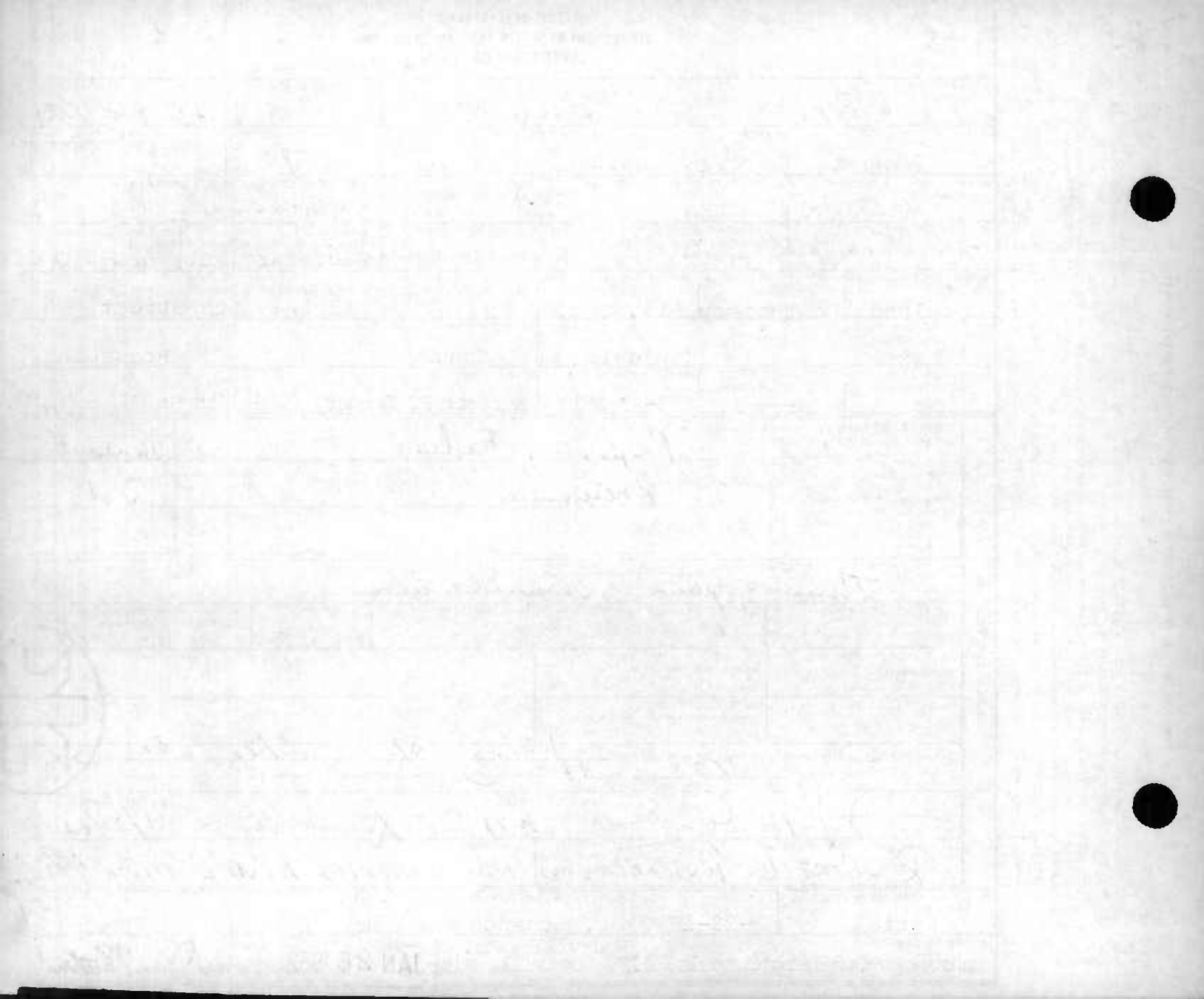
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202093			
1. FOR STATE REGISTRAR				20. DATE OF DEATH MONTH DAY YEAR 1 20 82			
1. DECEASED NAME FIRST MIDDLE LAST Rhoda Budner				2b. HOUR 2:03pm			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 2 18 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary (Ret)		12b. KIND OF BUSINESS OR INDUSTRY AFL-CIO Off	
13a. STATE Maryland				13b. CITY OR TOWN Sil. Spg.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13d. STREET ADDRESS 8201 - 16th Street				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Pressman			
14. FATHER'S NAME FIRST MIDDLE LAST Max Kaplowitz				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-03-3620				17. INFORMANT ADDRESS Herbert W. Budner; 8201 16th St NW, SSpg, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia				2d.			
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Thrombocytopenia, Ovarian Cancer.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/26/81 to 1/20/82, that (1) (we) lost saw the deceased alive on 1/20 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. ROSENBERG, MD				22e. ADDRESS 1131 UNIVERSITY BLVD W, SILVER SPRING, MD 20912			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Mem Park Hyattsville, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marvin L. Buppert</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-23-1982</b>			2b. HOUR <b>10:25 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 11, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPET SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WOODWARD &amp; LOTHROP</b>	
13a. STATE <b>MD</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>DWIGHT BUPPERT</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHARLOTTA WEDI</b>			13e. STREET ADDRESS <b>12607-Gould Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II 218-05-5435</b>		17. INFORMANT ADDRESS <b>MARY ROSALIE BUPPERT SAME AS 13 WIFE</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 5698 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Exploratory Laparotomy-Enterotomy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atelectasis - Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION <b>1/6/82</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Lesion of Distal Ileum</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen D. Protos, MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN D. PROTOS, MD</b>						22e. ADDRESS <b>9801 GEORGIA AVE, SILVER SPRING, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>		
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James V. Nathan</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 0 9 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CARRIE Bredbenner</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>26</b> YEAR <b>82</b>			
3. SEX <b>Female</b>				2b. HOUR <b>8 P M</b>			
4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH <b>JUNE</b> DAY <b>11</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>MONTGOMERY</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>4504 RANDOLPH ROAD</b>	
14. FATHER'S NAME FIRST <b>HENRY</b> MIDDLE <b></b> LAST <b>BREDBENNER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>EMMA</b> MIDDLE <b></b> LAST <b>DALIOUS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>199-09-3748</b>		17. INFORMANT ADDRESS <b>MIRIAM A. WOOD SAME AS 13 DAUGHTER</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Cerebrovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>77</b> , 19 <b>82</b> , to <b>82</b> , that (1) (we) last saw the deceased alive on <b>19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b> DEGREE				22c. DATE SIGNED <b>1/21/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOBEL</b> ADDRESS <b>1600214</b>	
22e. ADDRESS <b>4701 RANDOLPH RD Rockville MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW ROSEMONT CEMETERY</b>		23d. LOCATION CITY OR TOWN <b>ESPV</b> COUNTY <b>PENNSYLVANIA</b> STATE	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 0 9 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vivian M. BURDETTE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 15, 1982</b>		2b. HOUR <b>4:24 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 15, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bel Pre Health Care Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Gaithersburg</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William King</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Burdette</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-36-9402</b>		17. INFORMANT ADDRESS <b>Margaret Duvall 8510 Damascus Road Damascus, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Organic Brain Syndrome</b> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YRS 4</b> <b>YR 3</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> , 19 <b>82</b> , to <b>1/15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Raymond T. Benack, M.D.</b>				22c. DATE SIGNED <b>1/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Raymond T. Benack, M.D.</b>				22e. ADDRESS <b>415 Colie Dr., Wheaton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarksburg Montg. Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Olin L. Molesworth, P.A., Damascus, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>				25b. REGISTRAR'S SIGNATURE <b>Frances Jean Wether</b>	

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 0 9 7			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Sidney H BURGESS					2a. DATE OF DEATH MONTH DAY YEAR JAN 19, 1982 11 A.M.					2b. HOUR			
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care Wheaton, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4004 Beverly Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST Sidney W. Burgess					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie R. Reid								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None				16b. SOCIAL SECURITY NO. 578 01 2436		17. INFORMANT Same as above ADDRESS Gladys Burgess (Wife)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis obliterans &amp; gangrene l. foot</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mra													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>65</u> , to Jan. 19, 19 <u>82</u> , that (I) (we) last saw the deceased alive on Jan. 12, 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) visit the body after death.													
22b. SIGNATURE Frederick Moomau M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-19-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK MOOMAU, M.D.						22e. ADDRESS 18111 Prince Philip Dr..OLNEY, Md. 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/20/82		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.					
24. FUNERAL DIRECTOR Hines/Rinaldi F.H.11800 N.H.Ave.S.S.Md.						25a. DATE REC'D. BY REGISTRAR JAN 21 1982		25b. REGISTRAR'S SIGNATURE James Jan Nathan					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

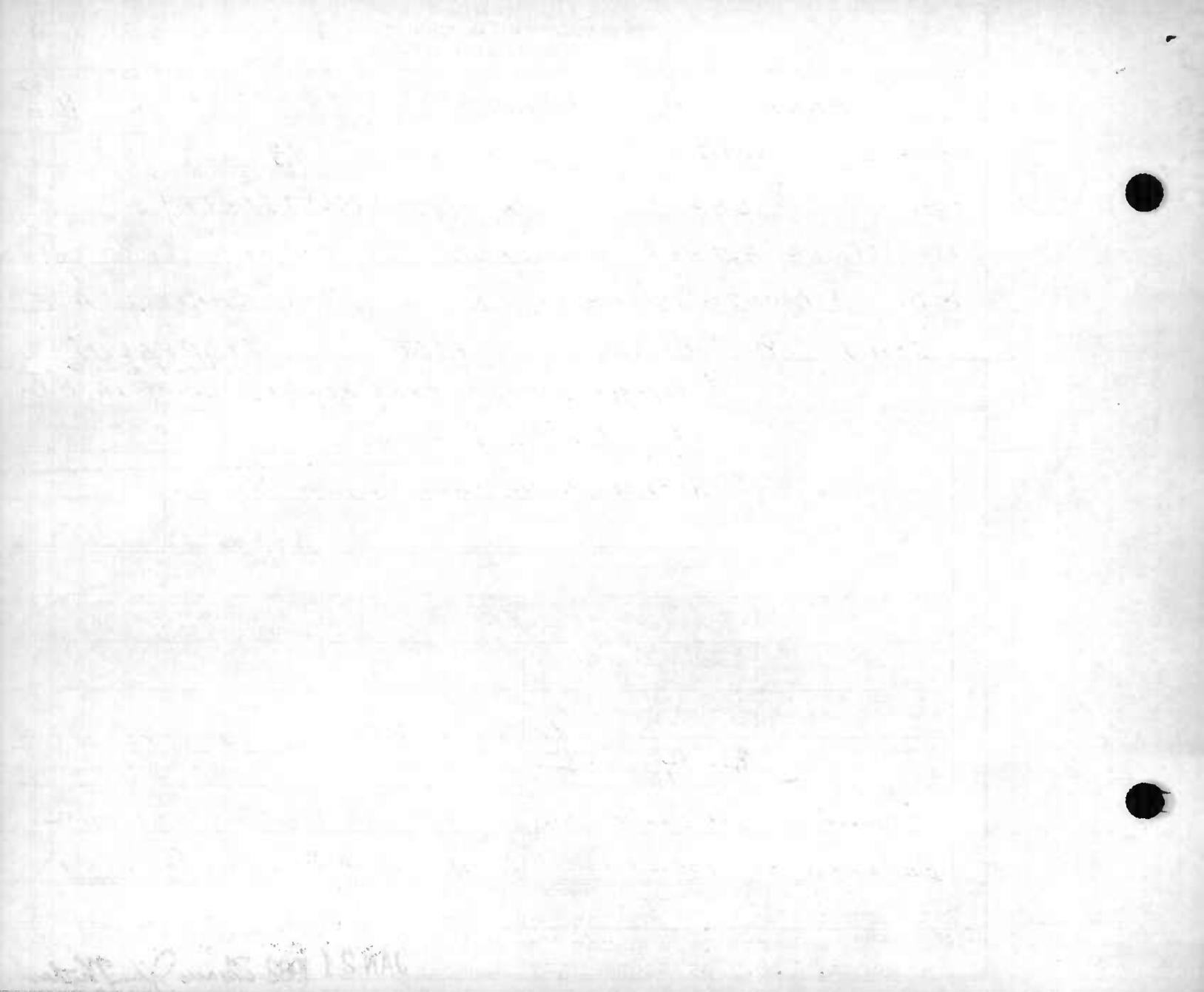
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA B. BURNS			2a. DATE OF DEATH MONTH DAY YEAR 1-14-82			2b. HOUR 10:42 AM			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12-5-1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ALTHEA WOODLAND				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stenographer		12b. KIND OF BUSINESS OR INDUSTRY Coal Co.	
13a. STATE MD.		13b. COUNTY MONTG.		13c. CITY OR TOWN TAKOMA PK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7051 CARROLL AVE	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN B. BRADY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE ZIMBERLIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 179-36-0671		17. INFORMANT ADDRESS ROSEMARY ROGERS BETHESDA, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4292 DUE TO, OR AS A CONSEQUENCE OF b. Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 217 UNIV. BLVD. E, SILVER SPRING MD				
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Jan 14 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) saw the body after death.									
22b. SIGNATURE Bernard A. Fitzgerald MD					DEGREE		22c. DATE SIGNED 1/14/82		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD					22e. ADDRESS 217 UNIV. BLVD. E, SILVER SPRING MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE January 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR JAN 21 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Kathan		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 0 9 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Wilson L Butcher</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 20 82</b>			
3 SEX <b>Male</b>				2b. HOUR <b>6:45 P.M.</b>			
4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Courtesy Care Center Ave. Sil. Spg. Hse</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Rep. Bon Ton Hatatoo Chip</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Co.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Md.</b> 13c. CITY OR TOWN <b>Montgomery Sil. Spr.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Marion Butcher</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Stevens</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>579-01-8648</b>			
17. INFORMANT ADDRESS <b>10203 Capital View</b>				17. INFORMANT NAME <b>Evelyn P. Butcher Ave. Sil. Spr., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardio resp. arrest</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic cerebrovas. dis</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>terminal</b> <b>3 days</b> <b>4 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 1-20</b> 19 <b>80</b> , to <b>1-20</b> 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>1-20</b> 19 <b>82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> view the body after death.							
22b. SIGNATURE <b>George Sengstack M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George Sengstack, M.D.</b>				22e. ADDRESS <b>9241 Columbia Blvd. S. S., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. National Cemetery Suitland Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>O. Box 7428 Sil. Spr., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 0 0

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Edwin A			A	Butler	January 5, 1982					1:30 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	CAUCASIAN		FEB 15 1909		72 YRS.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
NEW YORK	USA				MONTGOMERY COUNTY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Takoma Park	WASHINGTON ADVENTIST HOSPITAL		FEDERAL		Govt.						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS						
MARYLAND	PG.	Bowie		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12103 Tulip Grove Rd.						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
JAMES H. BUTLER				ANNA OBERG.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]				16b. SOCIAL SECURITY NO.		17. INFORMANT					
YES WWII				076-03-0387		Richard Snell 9055 Warfield Dr. Mt. Airy Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell lung cancer, Stage III										1 mo	
1629											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-4, 19 82, to 1-5, 19 82, that (I) (we) last saw the deceased alive on 1-5, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE Tai-Yin Yeung, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-6-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tai-Yin Yeung, M.D.				22e. ADDRESS 6525 Belmont Rd #460 Hyattsville, Md 20780							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL				11 JAN 82		PROSPECT Hill CEMETERY		GLOVERSVILLE NY.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE			
GRANT F.H. 9013 ANNAPOLIS Rd. LANHAM MD.				JAN 13 1982				[Signature]			

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MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. FOR  
STATE  
REGISTRAR

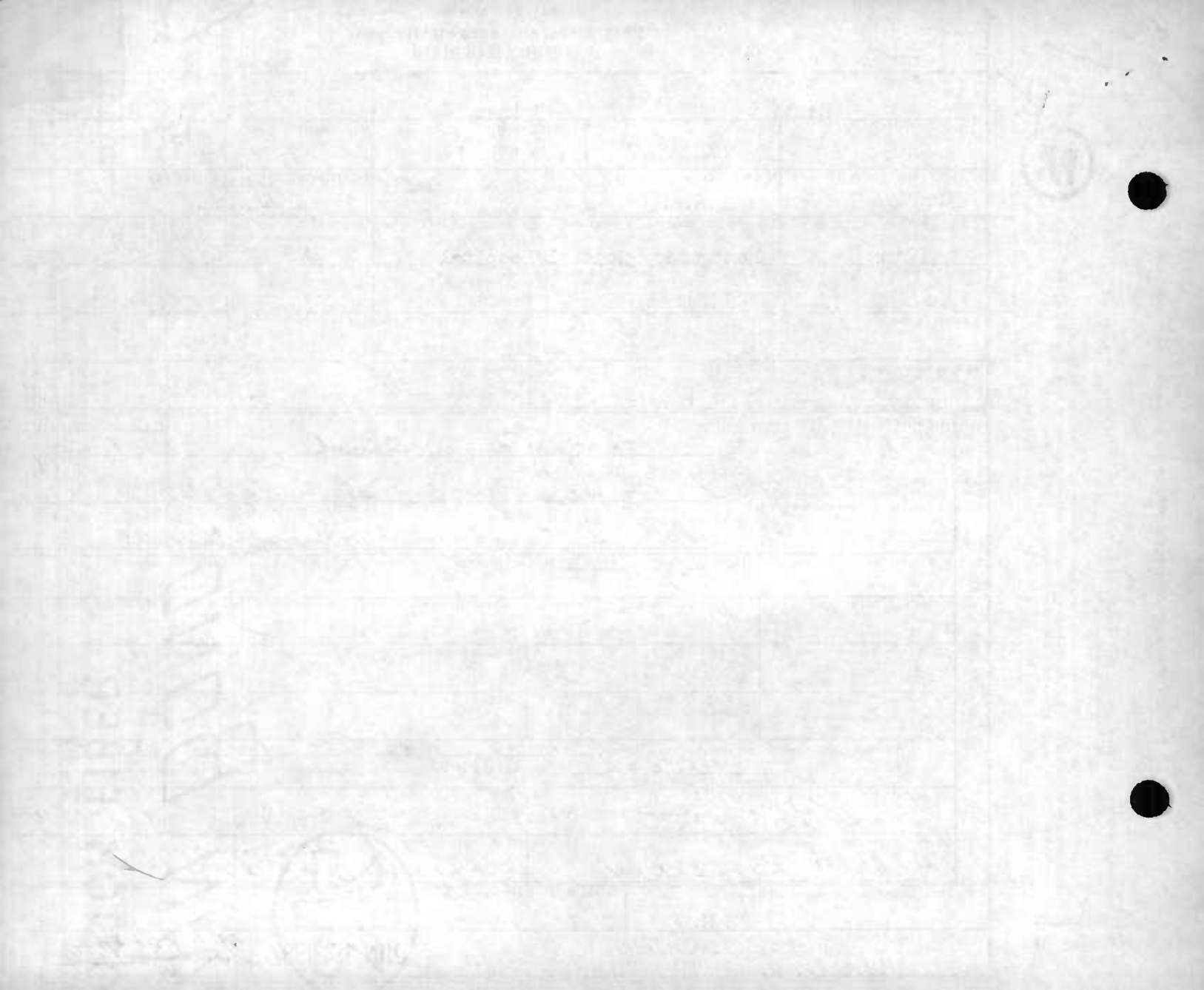
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Herbert M. Byrnes					1 10 82					2:27 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
MALE		CAUCASIAN		MAY 26, 1908		73 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital				MANAGER		S.S. KRESGE			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND				MONTGOMERY		WHEATON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12800 JINGLE LANE	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST JAMES M. BYRNES				FIRST MIDDLE LAST MARY FOUK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT					
YES				WW II		141-07-3774					
						HERBERT P. BYRNES SON 33 HORIZON HILL DR. POUGHKEEPSIE NEW YORK					

18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		1 day	
IMMEDIATE CAUSE (a) 4100			
DUE TO, OR AS A CONSEQUENCE OF			
(b) Acute Myocardial Infarction			
DUE TO, OR AS A CONSEQUENCE OF			
(c) Atherosclerotic coronary disease			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 1/10 19 82 to 1/10 19 82, that (2) we lost							
saw the deceased alive on 1/10/82 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I we; I did; I did not) saw the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
ALBERTO ROTSZTAJN		M.D.				1/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		3701 Rossmore Blvd S. Spring Md 20906					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		1/14/82		EAST HARRISBURG CEM		HARRISBURG PA	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS J. COLLINS				JAN 14 1982		Name J. J. J.	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



TO HOSPITAL-SEE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 0 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LEO J. CALLANAN			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5 1982			2b. HOUR 6 A M	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 18, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASSACHUSETTS		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1010 NORTH NOYES DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FOREIGN SERVICE		12b. KIND OF BUSINESS OR INDUSTRY OFF. STATE DEPT	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD J. CALLANAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELENA C. MURPHY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-36-2718		17. INFORMANT ADDRESS HELENE B. CALLANAN SAME AS 13 WIFE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic obstructive pulmonary disease</u> (c) <u>Surgery</u>						APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Cor Pulmonale Secondary</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> , 19 <u>75</u> , to <u>Jan 5</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Jan 5</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Barth J. Collins MD</u> DEGREE PH.D.				22c. DATE SIGNED 1-5-82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) 1407 W. Sideview Dr. Silver Spring Md 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/7/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25. DATE REC'D. BY REGISTRAR JAN 8 1982			



Chen. telephorophora 2/20/82  
 - 1st of 1st series

Chen. telephorophora 2/20/82

Chen. telephorophora 2/20/82  
 1-2-82  
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 1-2-82

JAN 8 1982

12

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02103			
1. DECEASED NAME (TYPE OR PRINT) <b>John Edward Campbell</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 31 1982</b>			2b. HOUR <b>11:23</b>							
3. SEX <b>M</b>	4. RACE <b>Blk</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>19</b> YEAR <b>12 69</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD <b>Feb 3 1982</b>		2d. HOUR <b>11:23</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Monterey MD</b>							
10. CITY OR TOWN OF DEATH <b>Sil Spg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1600 Brunswick Ave Apt 404 Shop Harbor</b>				12a. USUAL OCCUPATION (TYPE FOR MOST OF WORKING LIFE) <b>Naval Ordnance</b>		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Mont</b> 13c. CITY OR TOWN <b>Sil Spg</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1600 Brunswick Ave Apt 404</b>								
14. FATHER'S NAME FIRST <b>William A.</b> MIDDLE <b>Campbell</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Annie M.</b> MIDDLE <b>Johnson</b> LAST <b></b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-16-3922</b>		17. INFORMANT <b>George Campbell Sandy Spring MD</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial Dis.</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Hypertensive Heart Dis.</b> 4029 DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Yrs.</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>													
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <b></b>		CITY OR TOWN <b></b>		COUNTY <b></b>		STATE <b></b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>John P. Rogers, M.D.</b>			TITLE (SPECIFY) <b>Dep.</b>						MEDICAL EXAMINER			DATE SIGNED <b>Feb 3 1982</b>	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <b></b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-6-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Montg</b> STATE <b>Md.</b>					
24. FUNERAL DIRECTOR NAME <b>George P. Snowden</b> ADDRESS <b>246 N. Wash. ST. Rockville, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 9 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Annie G. [Signature]</b>								





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 82 02104							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILLIAN E. CANTY						2a. DATE OF DEATH MONTH DAY YEAR Jan. 25, 1982		2b. HOUR 10 <sup>50</sup> PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 23, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Typist, Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Cheverly		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3401 Cheverly Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST William Fox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Estelle Littleford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 577 50 6260		17. INFORMANT ADDRESS June L. Abigail Same as #13 (Daughter)					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis A.S.C.U.D. DUE TO, OR AS A CONSEQUENCE OF (c) ORGANIC Brain Syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERM. YRS YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (his) hospital attended the deceased from 1/25 1982 to 1/25 1982, that (I) (we) last saw the deceased alive on 1/25 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not move the body after death.									
22b. SIGNATURE Donald R. Lewis MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/25/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD				22e. ADDRESS OLNEY, Md. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/82		23c. NAME OF CEMETERY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.			
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 20 1982		25b. REGISTRAR'S SIGNATURE [Signature]			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 0 5

1- FOR  
STATE  
REGISTRAR

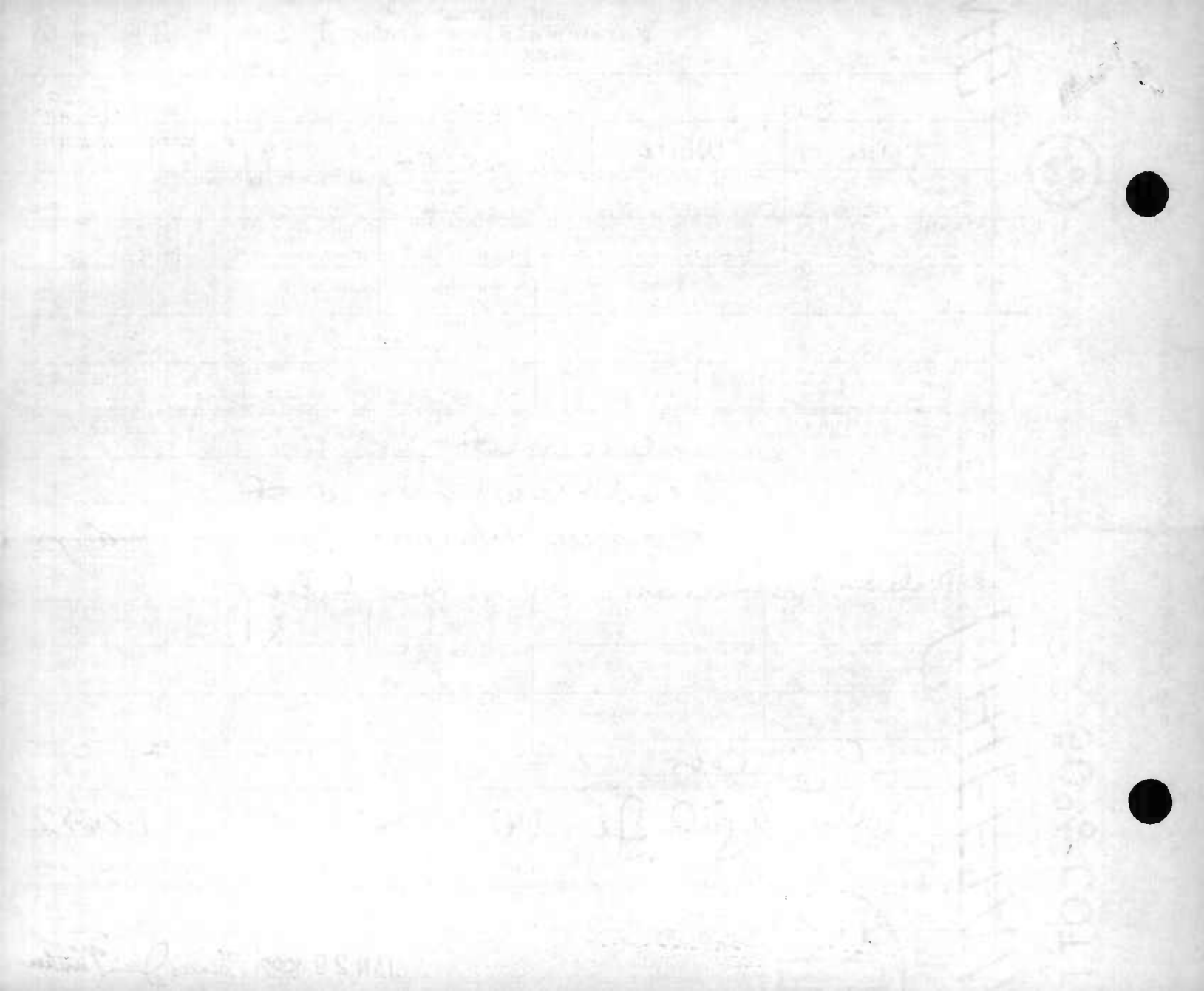
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Earl			FIRST MIDDLE LAST Carriek			2a. DATE OF DEATH MONTH DAY YEAR 1-26-82			2b. HOUR 3:20 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7-25-04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer-Ret.			12b. KIND OF BUSINESS OR INDUSTRY Printing				
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Sil. Spr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9319 Wire Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Carrick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Boswell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 577-10-3585			17. INFORMANT ADDRESS Elizabeth M. Carrick Sil. Spr., Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>convulsive arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> (c) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes, Hypertension, Coronary Heart Failure</u>													
19a. DATE OF OPERATION 1-25-82			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (a) this hospital attended the deceased from 1-26-82, 1982, to 1-26-82, 1982, that (b) the deceased (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mm) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz)													
22b. SIGNATURE John Kijak, Jr., MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-26-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Kijak, Jr., MD			22e. ADDRESS 17621 Tree Lawn Dr., Ashton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/27/82			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood Md.			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc., Sil. Spr., Md.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please reattach certificate papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Ethel R. CARTER					2a. DATE OF DEATH January 14, 1982			2b. HOUR 6:40 P M		
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH August 13, 1895		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Brookeville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 316 Market Street	
14 FATHER'S NAME Mark M. Webb					15. MOTHER'S MAIDEN NAME Mary Ann Dunkin					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 415-38-4636		17 INFORMANT ADDRESS Mary Beal, 17060 King James Way, #602 Gaithersburg, Maryland 20877					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS 40 YEARS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS 11 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/14/82 to 1/14/82, that (I) (we) lost saw the deceased alive on 11/14/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Thos G. Ward MD					22c. DATE SIGNED 1/14/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos G. WARD					22e. ADDRESS 6116 ROBINWOOD, Bethesda, Md 20817					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE January 17, 1982		23c. NAME OF CEMETERY OR CREMATORY Longfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lake City, Tennessee			
24 FUNERAL DIRECTOR NAME Ives Funeral Home 2847 Wilson Blvd., Arlington, VA 22201					25a. DATE REC'D. BY REGISTRAR JAN 24 1982					
25b. REGISTRAR'S SIGNATURE Renee Jones										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					7 2 0 2 1 0 7				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Julia T. Cavaliere					1-23-82				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
Female		White		Feb. 14, 1892		89 YRS.		6:45A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash., D.C.		U.S.A.				Mont.		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Housewife		-	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Md.		Pr. Geo.		Hy.				2600 - Queens Chapel Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
George Flynn					Ida (Unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No					579-24-4310		Emanuele Cavaliere (Son) Same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic CHF 2 L sided pleural effusion</u> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Aortic Stenosis Heart murmur</u> (c) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1981</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>HBP, CAD, Renal Failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>12-12-80</u> , 19 <u>80</u> , to <u>1/23/82</u> , 19 <u>82</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>1/22/82</u> , 19 <u>82</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
G B Patnick MD		9221 Cokerville Rd Silver Spring, Md 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-27-82		Cedar Hill Cem.		Suitland Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Nalley's F.H. Inc. Mt. Rainier, Md.						FEB 1 1982		[Signature]	

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Giuseppe G. Ciatto</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/1/82</b>		2b. HOUR <b>7<sup>32</sup> AM</b>
3. SEX <b>male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sicily</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Taxi Driver</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Transportation</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3500 Weller Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pasquali Ciatto</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Paola Romeo</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-16-6206</b>		17. INFORMANT <b>son Patrick F. Ciatto</b> ADDRESS <b>19017 Wootton Ave. Pollesville, Md.</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Lung Disease</b> DUE TO, OR (c) <b>Congestive Heart Failure</b> <b>Underlying Cause: Coronary Artery Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 years</b> <b>2 days</b> <b>12 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Recurrent pneumonia and pleural effusions</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1982 12-30 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12-30-81</b> to <b>1/1-82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John A. Galotto MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-1-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John A. Galotto MD</b>		22e. ADDRESS <b>5225 Rock Hill Rd, Bethesda, Md 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>		24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>			

MEDICAL CERTIFICATION

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JAN 15 1951

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 1 0 9			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										ESTIMATED		MONTH DAY YEAR	
3 SEX MALE 4 RACE WHITE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.										IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA 7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL										12a. USUAL OCCUPATION (TYPE OF WORK) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY TOOL COMPANY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 10007 REDDICK DR.	
14. FATHER'S NAME FIRST MIDDLE LAST HUGH P. CLARK										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY RYAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES 16b. SOCIAL SECURITY NO. 344-07-5842										17. INFORMANT EVELYN R. CLARK WIFE SAME AS 13		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arter. Sclerosis Vaso. DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) M.D. Dr. P.		MEDICAL EXAMINER	
ACTUAL SIGNATURE [Signature]										DATE SIGNED Jan 15 1982			
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.C.										ADDRESS 1919 SEMINARY ROAD SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION										23b. DATE JAN. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD.										23d. LOCATION CITY OR TOWN ALEXANDRIA		COUNTY VIRGINIA	
25a. DATE REC'D. BY REGISTRAR JAN 21 1982										25b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED  
JAN 10 1900

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 1 1 0			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHRISTOPHER SUDLOW CLAYTON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 21, 1982</b>			2b. HOUR <b>2:28 PM</b>					
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 1, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3632 EDLEMAR TERRACE SILVER SPRING, MARYLAND 20906</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>VIRGIL P. SUDLOW CLAYTON</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JESSIE SUDLOW</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>					16b. SOCIAL SECURITY NO. <b>1942-1972</b>		17. INFORMANT ADDRESS <b>3632 EDLEMAR TERRACE ANNA D. CLAYTON: SILVER SPRING, MD 20906</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b>													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>14 DECEMBER, 1981</b> to <b>21 JANUARY, 1982</b> , that (I) (we) lost saw the deceased alive on <b>21 JANUARY, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M. S. Gurney</i>				DEGREE <b>LT MC</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/22/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. S. GURNEY, LT, MC, USNR</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 27, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Va.</b>					
24. FUNERAL DIRECTOR <i>William Kellers</i>				25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>HELEN M. CLEAVES</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 6, 1982</b>			2b. HOUR DAY MIN. <b>1:45 A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 9, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		7. UNDER 1 YEAR MONTHS DAYS <b>66</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> County MD.				
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Admin. Assistant U.S. Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alvin Miller</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Stoevers</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-44-6533</b>		17. INFORMANT ADDRESS <b>Richard B. Cleaves, Same as #13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular fibrillation</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>myocardial infarction, recent</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>coronary heart disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>12 hr</b> <b>-</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>11125 ROCKVILLE PIKE, ROCKVILLE, MD</b>			21g. CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <b>SEPT 1976</b> to <b>1-5 1982</b> , that (I) (we) lost saw the deceased alive on <b>1-5 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas G. Sinderson, MD</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>1-6-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS G. SINDERSEN, MD</b>					22e. ADDRESS <b>11125 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 8, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Jean Nathan</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
1. FOR STATE REGISTRAR			REG. NO. 8 2 0 2 1 1 2												
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
MARIE W. CLIFFORD			JAN. 18, 1982									9:45 AM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female			White			Aug. 14, 1891			90 YRS.			MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Oregon			US						Montgomery						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Gaithersburg			Wilson Health Care Center.			Lighting Advisor			Elect. Co.						
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md.			Montgomery			Gaithersburg			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			107-A Summit Ave.			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Williams C. Wells			Laura Belle Geiger												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
No			302-07-4003			Joseph W. Clifford			4108 Rosemary St. C.C. Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i>										151					
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>										60 d.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Coronary atherosclerosis</i>										10 yrs					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Osteoporosis Gen. ASVD C.H.D.</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED									
			HOUR A.M. MONTH DAY YEAR			(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]			STREET			CITY OR TOWN			COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/15/82</i> to <i>1/18/82</i> . That (I) (we) last saw the deceased alive on <i>1/15/82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE			22c. NAME OF DEGREE			22d. ADDRESS			22e. DATE SIGNED						
<i>Stephen N. Jones, M.D.</i>			STEPHEN N. JONES, M.D.			809 VIERS MILL RD. ROCKVILLE, MD.			1/18/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED									
Stephen N. Jones, M.D.			809 Viers Mill Rd. Rockville, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION						
Burial			1/20/82			Rock Creek Cem.			Washington, D.C.						
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Joseph Gawler's Sons, Inc.			JAN 22 1982			Charles J. Nathan									
NAME			ADDRESS												
5130 Wis. Ave. N.W. Wash., D.C.															

1982 JAN. 18, 1982

CLAYTON

W.

MALE

90

1981 JAN. 18, 1981

White

Female

Montgomery

XX

US

Green

Livingston Adams Assoc. Co.

Wilson Health Care Center

Washington

101-10000 Ave.

Washington x

Montgomery

MA.

Denver

Belle

Lincoln

Wells

Williams

302-07-1002

10

Joseph W. Clifford - 10000 Ave. 101-10000

302 West 10th St. Rockville, MD.

Stephen H. Jones, M.D.

Washington, D.C.

Rock Creek Park

1/20/82

Initial

Joseph Jones's name, etc.

1000 Ave. N.W. Wash., D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO. 8202113								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		YEAR		2b. HOUR	
DORA COHN			JANUARY 5, 1982						2:15 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		JANUARY 14, 1894		87		YRS.		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA		U.S.A.				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		HOUSEWIFE		OWN HOME					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
MARYLAND			MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1401 BLAIR MILL ROAD, APT 714		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
HERSHEL GALPERIN			(UNASCERTAINABLE) CHERNA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			579-50-5324			SYLVIA DUNKELMAN, SILVER SPRING, MARYLAND			1806 TILTON DRIVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
2506 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>										1d.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gangrene of foot</u>										3-4d.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Dilated Myocardium, Atherosclerotic Heart Disease.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
						1/4			1/4		
22a. I certify that (this hospital) attended the deceased from 1/4 1982, to 1/4 1982, that (I/we) last saw the deceased alive on 1/4 1982, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
ROBERT L. ROSENBERG, MD			MD						1/5/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
			1131 UNIV. BLVD W., SILVER SPRING, MD.								
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			1/7/1982		ADAS ISRAEL CONGREGATION CEMETERY		WASHINGTON, D. C.				
24. FUNERAL DIRECTOR: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.											
25a. DATE REG'D. BY REGISTRAR: 25b. REGISTRAR'S SIGNATURE: JAN 11 1982 Frances Jean Nathan											



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HATTIE COLEMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 15, 1982</b>			2b. HOUR <b>6:05p m</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 14, 1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>67 years</b>		6. IF UNDER 24 HRS. HOURS MIN. <b>---</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEKEEPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEO'S</b>		13c. CITY OR TOWN <b>LANDOVER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3540 EDWARDS STREET</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>260 09 4382</b>			17. INFORMANT <b>DOROTHY McCLENDON</b>			ADDRESS <b>3540 EDWARDS ST., LANDOVER, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of stomach</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteric Aneurysm</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1481</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CAD, Pneumonia, NG tube feedings, CHF, Anemia</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NO</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>5/8/79</b> , 19____, to <b>1/15/82</b> , 19____, that (I) (we) lost saw the deceased alive on <b>1/14/82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>JB Patrick III MD</b>				DEGREE				22c. DATE SIGNED <b>1/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>6 B Patrick III MD</b>				22e. ADDRESS <b>9221 Glenville Rd Silver Spring, Md 20990</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/20/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>LANDOVER, MARYLAND</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROLLINS FUNERAL HOME, INC. 4339 HUNT PL. N.E.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 6 9 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

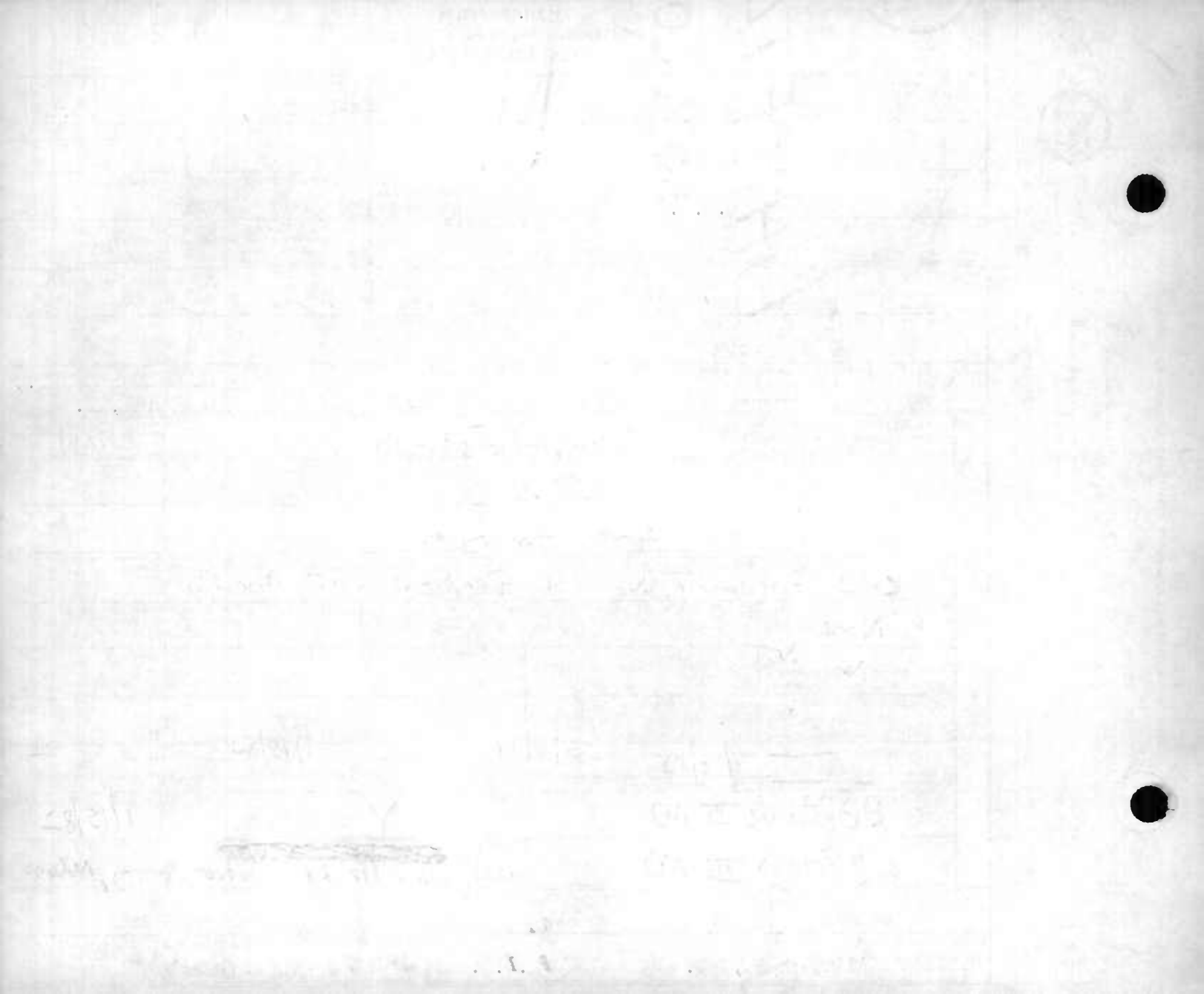
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

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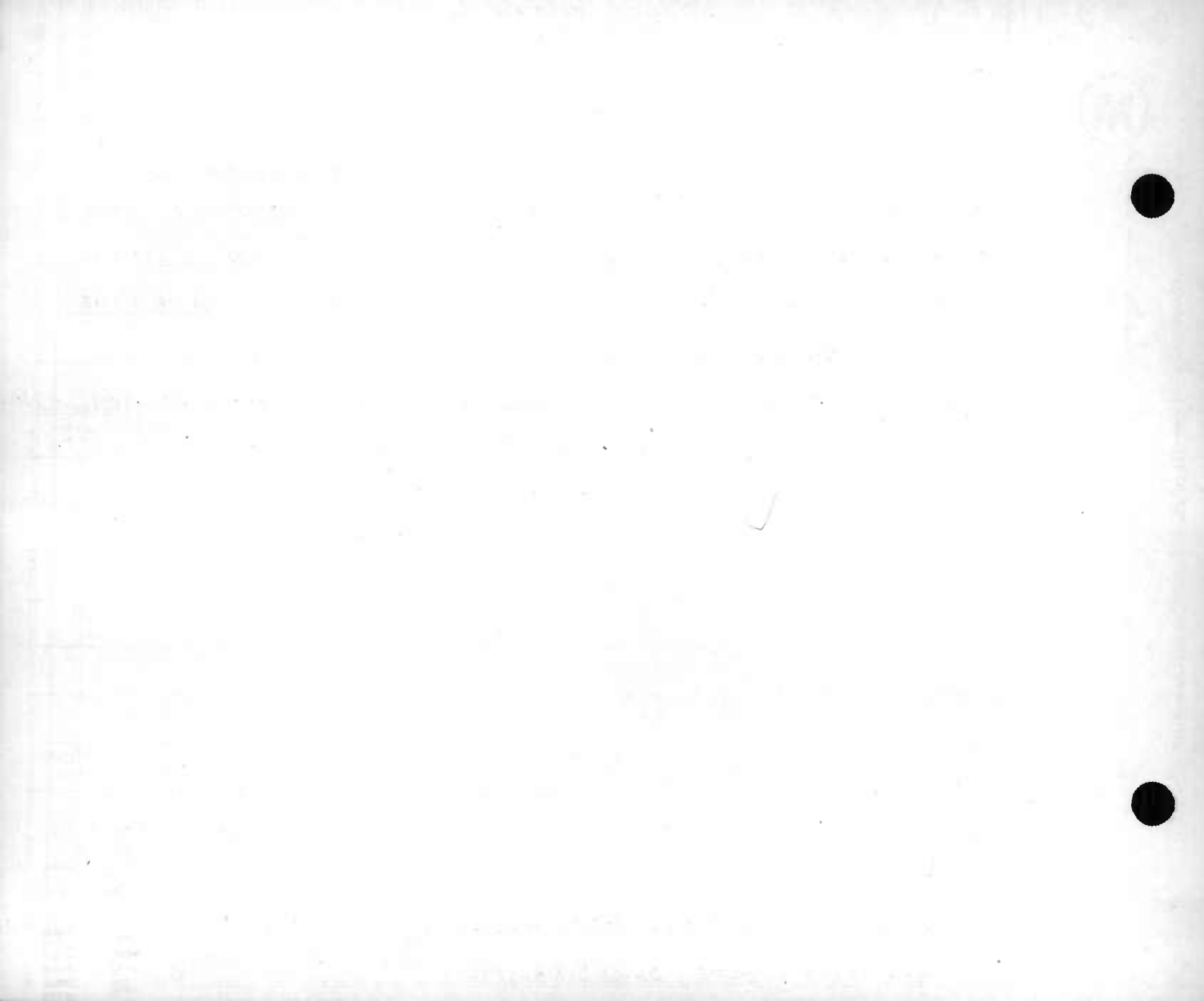
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202115			
1. DECEASED NAME (TYPE OR PRINT) <b>MAGELLAN COLEMAN</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>82</b>			
3 SEX <b>MALE</b>		4 RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>14</b> YEAR <b>14</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BEL-PRE NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>REPAIRMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>BOILERS</b>	
13a. STATE <b>-</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>WASHINGTON, DC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		15 MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			
16b. SOCIAL SECURITY NO <b>UNKNOWN</b>		17 INFORMANT <b>ESTHER J. LEWIS</b>		ADDRESS <b>P.O. BOX 413 FORK UNION, VA. 23055</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion of the Lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION <b>3-15-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>12-31-81</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3-15-82</b> to <b>Jan 3, 1982</b> , that (I) (we) lost saw the deceased arrive on <b>12-31-81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Michael R. Dobridge</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>January 2, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael R. Dobridge M.D.</b>		22e. ADDRESS <b>13975 Connecticut Ave Silver Spring, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN 5, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND, P.G. CO. MARYLAND</b>	
24 FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>		ADDRESS <b>SILVER SPRING, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL H. COLLIER</b>						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX <b>Female</b>						4. RACE <b>white</b>		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>						7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silo Spring</b>						11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b>					
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montg.</b>						13c. CITY OR TOWN <b>Silver Spring</b>					
14. FATHER'S NAME <b>Frank Hegner</b>						15. MOTHER'S MAIDEN NAME <b>Mary White</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>579-48-4422</b>					
17. INFORMANT <b>James R. Collier</b>						ADDRESS <b>Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>diabetes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c)										19. PERMANENT INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>diabetes mellitus</b>											
20a. DATE OF OPERATION				20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OF PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from <b>1/25/82</b> to <b>1/25/82</b> that (we) lost saw the deceased above on <b>1/25/82</b> and then in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If over, did not view the body after death.)											
22b. SIGNATURE <b>B.N. ROSENBAUM, M.D.</b> DEGREE <b>M.D.</b>										22c. DATE SIGNED <b>1/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>3720 FARRAGUT AVE. KENSINGTON, MD 20745</b>										22e. ADDRESS <b>B.N. ROSENBAUM</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>January 28, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bladensburg, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>			25b. REGISTRAR'S SIGNATURE <b>Thomas J. Smith</b>		

MEDICAL CERTIFICATION

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Cleared by Dr. Rogers

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 1 1 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Cora Mae Collins</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 2 82</b>		2b. HOUR <b>12 15 PM</b>			
3. SEX <b>F</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 25 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>78</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>						13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Clarksburg</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>(Unknown) Grant</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Smith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>404-03-7643</b>		17. INFORMANT ADDRESS <b>Margie Willis-Daughter-Same as #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4/289 Heart failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Presbyesophagus with chronic aspiration</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/80</b> , 19____, to <b>1/2</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/2</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Cheryl Winchell</b>						DEGREE		22c. DATE SIGNED <b>1/2/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Cheryl Winchell</b>						22e. ADDRESS <b>19241 Montgomery Village Ave</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 7, '82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grant Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mendota Virginia</b>	
24. FUNERAL DIRECTOR <b>Hill Funeral Home</b>						25. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Alma</b>			

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Own Home

Hennsville

Shady Grove

15415 Census Rd.

Montgomery Clearmont

Maryland

Belin

Minnie

Grant

(Unknown)

Maria Willis-Daughter-Grand ne 513

404-12-7643

No

Virginia

Wendola

Jan. 7, '82 Grant Cemetery

Berlin

Hennsville, Md.

Hilton Funeral Home



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

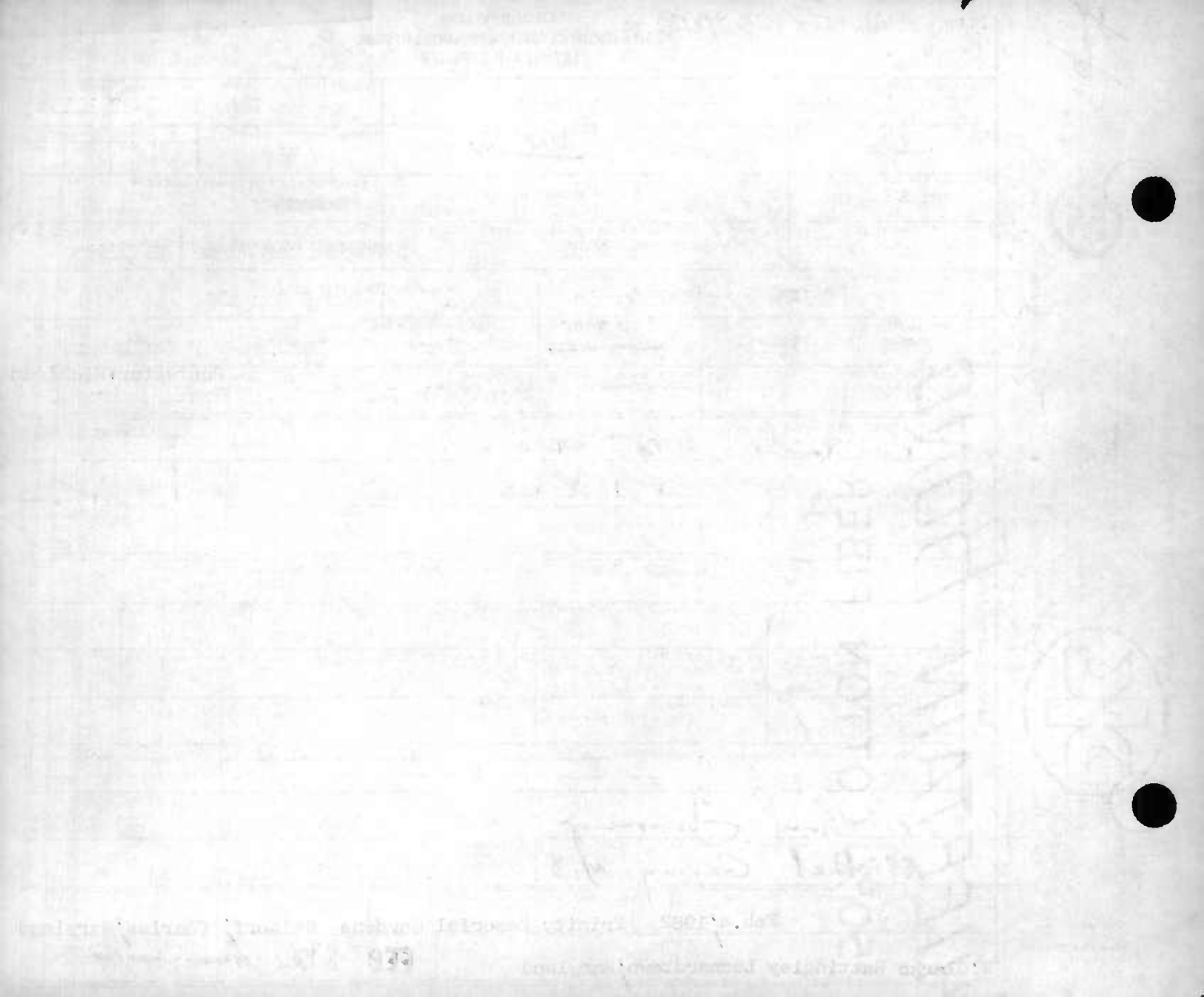
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Alice Queenie Connick</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 31 1982</b> 2b. HOUR <b>1015am</b>			
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Nov. 07, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Naval Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Registered Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD Office</b>	
13a. STATE <b>MD</b>				13b. CITY OR TOWN <b>Saint Marys California</b>		13c. STREET ADDRESS <b>Rt. 2 Box 138</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Henry Bierwager</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Harriet McCellan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577345956</b>		17. INFORMANT ADDRESS <b>Pentwater, Michigan</b> <b>Mrs. Della Lankfer Rt. 2 Scenic Drive MI</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY. <b>Renal Failure</b> IMMEDIATE CAUSE (a) <b>2030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan 15</b> , 19 <b>82</b> , to <b>Jan 31</b> , 19 <b>82</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan 31</b> , 19 <b>82</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, or <input type="checkbox"/> (we) did not view the body after death.							
22b. SIGNATURE <b>Michael Gurney</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>31 Jan 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael Gurney M.D.</b>				22e. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Waldorf, Charles, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>W. Clarke Mattingley Leonardtown, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>			
25b. REGISTRAR'S SIGNATURE <b>Howe</b>							

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) HARRY STEWART COPPERTHITE JR					2a. DATE OF DEATH MONTH DAY YEAR XX JANUARY 29, 1982			2b. HOUR 3:52 AM		
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MARCH 25, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 53		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US AIR FORCE,		12b. KIND OF BUSINESS OR INDUSTRY RETIRED		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HARRY STEWART COPPERTHITE SR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE SELLERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1946-1976		17. INFORMANT SON, MARK A. COPPERTHITE		ADDRESS 9316 GUNPOWDER PL, GAITHERSBURG, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <del>XX</del> SQUAMOUS CELL CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 28 DECEMBER 1981, to JANUARY 29 1982, that (I) (we) last saw the deceased alive on JANUARY 29 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. L. REED					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 29 JAN 1982		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. REED, LTMC USNR					22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/2/1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia				
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.					25. DATE REC'D. BY REGISTRAR FEB 4 1982		26. REGISTRAR'S SIGNATURE [Signature]			

22

White



xx

130 West 4th St., New York, N.Y.  
Joseph A. Davis, Inc.  
2/5/1982  
Washington National Bank  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

item 22c #G564 2/3/82 ph

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES EARL COWAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 3, 1982</b>		2b. HOUR <b>7:55 p.m.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 8, 1923</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>58</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TEXAS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. <b>BALTIMORE CITY OR</b> COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dry Cleaner</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Cleaning</b>	
13a. STATE <b>VIRGINIA</b>			13b. CITY OR TOWN <b>WARSAW</b>	13c. STREET ADDRESS <b>P.O. Box 406 WARSAW, VIRGINIA 22572</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EARL N. COWAND</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAYE PARKER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>1942-1966 458-20-4237</b>		
17. INFORMANT <b>MAXINE COWAND: WARSAW, VIRGINIA 22572</b>			ADDRESS <b>P.O. Box 406</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1489 SQUAMOUS CELL CARCINOMA OF HYPOPHARYNX WITH METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>26 SEPTEMBER 19 81</b> , to <b>03 JANUARY 19 82</b> , that (I) (we) last saw the deceased alive on <b>03 JANUARY 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Daniel Range</i>				22c. DATE SIGNED <b>4 JAN 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. R. RANGE, MAJ, MC, USAF</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>		23e. INTERVIEWED BY (NAME AND ADDRESS) <b>JAN 11 1982 Thomas J. Nathan</b>			
24. FUNERAL DIRECTOR NAME <i>Wayne F. F. Lee</i> ADDRESS <b>Demaine Funeral Homes, Inc., Alex., Va. 22314</b>					



1003 JAN 17 1952

U.S. AIR FORCE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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DHMH-16 50M 1/81  
(VRA 15, 4)

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 1 2 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>Paul F. CRAUN</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1- 2- 82</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		2b. HOUR <b>903 P M</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>3 14 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Wash. Post-Ret. Newspaper</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen H. Craun</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mamie Redner</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-03-4134</b>		17. INFORMANT ADDRESS <b>Eleanor C. Craun-Same as items 13a-e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SNOCK</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE CORONARY ARTERY DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 HRS</b> <b>24 HRS</b> <b>2 1/2 YRS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES, PERIPHERAL VASCULAR DISEASE, CEREBROVASC. DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6 19 79</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <b>1/3/82</b>		21h. SIGNATURE <b>ROGER STEVENSON, JR MD</b>	
22a. I certify that (1) this hospital attended the deceased from <b>1/2 19 82</b> to <b>1/2 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, and (2) I did not examine the body after death.		22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER STEVENSON, JR MD</b>		22c. ADDRESS <b>11125 ROCKVILLE PIKE, ROCKVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/4/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>		24. FUNERAL DIRECTOR'S NAME <b>Tyson Wheeler Funeral Home, Inc.</b>		25a. DATE OF BY REGISTRATION <b>JAN 7 1982</b>	
25b. ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>		25c. SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION  
Cleared by Med. Ex.

0802 BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 2 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MAUD MIDDLE WARNER LAST CRICHTON			2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1982		2b. HOUR 5:51 a.m.
3. SEX FEMALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 23, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE VIRGINIA			13b. COUNTY FAIRFAX	13c. CITY OR TOWN McLEAN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST SEWELL MIDDLE LAST WARNER			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE ELIZABETH LAST FRANKLIN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-52-6300		17. INFORMANT NEIL A. CRICHTON: BETHESDA, MARYLAND 20814	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>14 JANUARY 1982</u> to <u>24 JANUARY 1982</u> , that (I) (we) last saw the deceased alive on <u>24 JANUARY 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>K. Lee</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 1-25-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. LEE, LT, MC, USNR		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/28/82	23c. NAME OF CEMETERY OR CREMATORY Arl. Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arl. Va.
24. FUNERAL DIRECTOR NAME Joseph H. Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.			25. RECEIVED BY REGISTRAR 1 FEB 2 1982		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

20% COTTON LIGER

WATER MARK

100% COTTON LIGER  
MADE IN U.S.A.  
WATER MARK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR					
FIRST MIDDLE LAST			MONTH DAY YEAR			HOUR MIN.					
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		
Male			white		MONTH DAY YEAR		79		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Davis, West Va.			U.S.A.					Montgomery MD.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring			Holy Cross Hospital			Baker		Bakery			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md.			Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14210 Grand Pre Road Apt. 103		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST						FIRST MIDDLE LAST					
Louis W. Currence						Dessie Mae Rogers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No						335-03-9203A		Ruby D. Currence 14210 Grand Pre Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Pneumonia											
DUE TO, OR AS A CONSEQUENCE OF (b) Organ Brain Syndrome											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE						
22a. certify that (I) (this hospital) attended the deceased from 6/1/82 to 6/1/82, that (I) (we) last saw the deceased alive on 6/1/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
H-ELG						X			6/5/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS			22f. SIGNATURE		
H-ELG						1801 Georgia Ave			Silver Spring Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
Burial			Jan. 6, 1982		Maplewood		Elkins, West Va.				
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Murphy Funeral Home-Falls Church, Va.						JAN 7 1982		[Signature]			



COPIES

Handwritten signature or name, possibly "C. J. [unclear]".

100 100 100 100 100 100 100 100 100 100

Handwritten notes and signatures at the bottom of the page, including a large signature on the left and several smaller notes and initials on the right.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (3))  
15M 2/80

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02124									
1. DECEASED NAME (TYPE OR PRINT) <b>Westley F. Curtis</b>										2a. DATE KNOWN OF DEATH <b>Jan 4 1982</b>										2b. DATE OF DEATH <b>Jan 4 1982</b>																			
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>11-15-04</b>		6. AGE (IN YEARS) <b>77 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>Jan 4 1982</b>		2d. HOUR <b>8:30 PM</b>		2e. HOUR <b>8:30 PM</b>																							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>				MD.																							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physicist</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept.</b>																											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13b. STREET ADDRESS <b>9499 MacArthur Blvd., 20817</b>																			
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Bethesda</b>										14. FATHER'S NAME <b>Justin Curtis</b>										15. MOTHER'S MAIDEN NAME <b>Olive Farnsworth</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>216 44 9841</b>										17. INFORMANT <b>Wife: Thelma B. Curtis</b> ADDRESS <b>Same as #13</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4110 coronary Insufficiency Acute</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE <b>John G. Ball</b>										TITLE (SPECIFY) <b>M.D. Deputy</b>										DATE SIGNED <b>Jan 4, 1982</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>										ADDRESS <b>Bethesda, Md. 20814</b>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>										23b. DATE <b>Jan. 6, 1982</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Va.</b>																			
23d. LOCATION CITY OR TOWN <b>Montgomery</b> COUNTY <b>Montgomery</b> STATE <b>MD.</b>										24. FUNERAL DIRECTOR NAME <b>Pearson's Funeral Home</b> ADDRESS <b>Falls Church, Va. 22046</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Ball</b>																			

DHMH-17  
(VR A15 ME (3))  
15M 2/80

Jan 4 1882  
Westminster

Comr

Noted

Barthel's Suburban

Colonial Insurance Acct  
Cordoba's Acct

Jan 4 1882  
x x

John D. Bell Deputy



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR			REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			2b. HOUR	
LUBA T DANCY						1 17 82			7:50A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		
Female		Caucasian		6 15 1890		91 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
TZERVO BULGARIA		USA				MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
SANDY SPRING		FRIENDS NURSING HOME				SEC. WORKER-TEACHER				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. CITY OR TOWN			13b. INSIDE CITY LIMITS?			13c. STREET ADDRESS	
13a. STATE			13b. COUNTY			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			17340 QUAKER LANE	
MD			MONTGOMERY							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST			FIRST MIDDLE LAST							
CHRISTO TZVETANOFF			CHRISTINA PETROVIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS	
NO			117-36-50897			Ray D. Brown/Daughter/			2204 Martha Road Alexandria, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma</u> <u>2028</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did not) view the body after death.			19 <u>76</u> to <u>17 Jan</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>31 Dec</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
<u>Donald E. Dillon M.D.</u>			M.D.						<u>17 Jan 82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
Donald E. Dillon, M.D.			18111 Pr Philip Dr Olney, Md 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
CREMATION			Jan 17/1981		LEE'S CREMATORY		WASHINGTON DC			
24. FUNERAL DIRECTOR NAME			24b. ADDRESS			25a. DATE BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
CAROL FUNERAL SERVICE			FAIRFAX, VA			JAN 17 1982				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

82 02126

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marshall N Day		2a. DATE OF DEATH MONTH DAY YEAR January 29, 1982		2b. HOUR 1940M
3. SEX male	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11 4 98		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY State Rd, Comm.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTG 13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1135 University Blvd. W.	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH DAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA Gibbs		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-9560		17. INFORMANT ADDRESS Irene L. Day (wife) Same as #13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: 1599 IMMEDIATE CAUSE (a) Cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute metastatic GI carcinoma 2 yrs DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Renal failure, dehydration				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. LOCATION STREET CITY OR TOWN COUNTY STATE
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE K A R E S H		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/29/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K A R E S H		22e. ADDRESS 15 E Deer Park East Rocking		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-3-82	23c. NAME OF CEMETERY OR CREMATORY JOHN WESLEY Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Clarksville Montgomery Md.		23e. DATE REC'D. BY REGISTRAR FEB 4 1982		
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 246 N. WASH. ST. Rockville, MD.		

24. FUNERAL DIRECTOR

NAME

George R. Snowden

24b. ADDRESS

246 N. WASH. ST.  
Rockville, MD.

23e. DATE REC'D. BY REGISTRAR

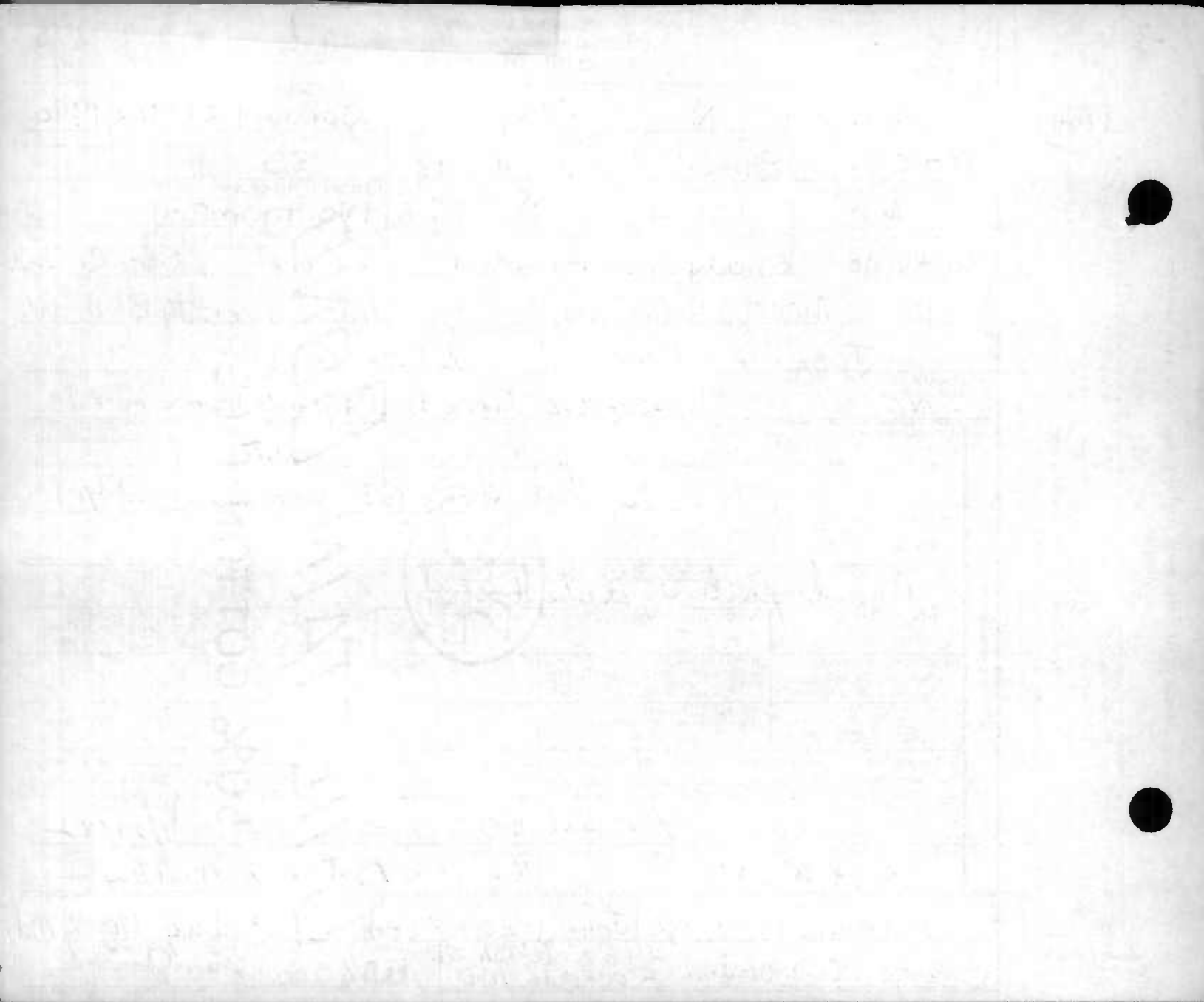
FEB 4 1982

23c. NAME OF CEMETERY OR CREMATORY

JOHN WESLEY Cem.

23d. LOCATION

Clarksville Montgomery Md.



# FOR STATE REGISTRAR MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Vincent Hobbs DAY</b>		2a. DATE KNOWN OF DEATH ESTI-MATED <b>Jan 16 1982</b>		2b. HOUR <b>2:10 A.M.</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>7</b> YEAR <b>01</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>80</b> YRS.	IF UNDER 1 YR. MONTHS <b>1</b> DAYS <b>1</b> HOURS <b>1</b> MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Postal Clerk</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Damascus</b>	
14. FATHER'S NAME FIRST <b>Columbus</b> MIDDLE <b>W.</b> LAST <b>Day</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Adelaide</b> MIDDLE <b>Hobbs</b> LAST <b>Hobbs</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-46-4731</b>		17. INFORMANT <b>Gladys S. Day</b>	
				ADDRESS <b>Item 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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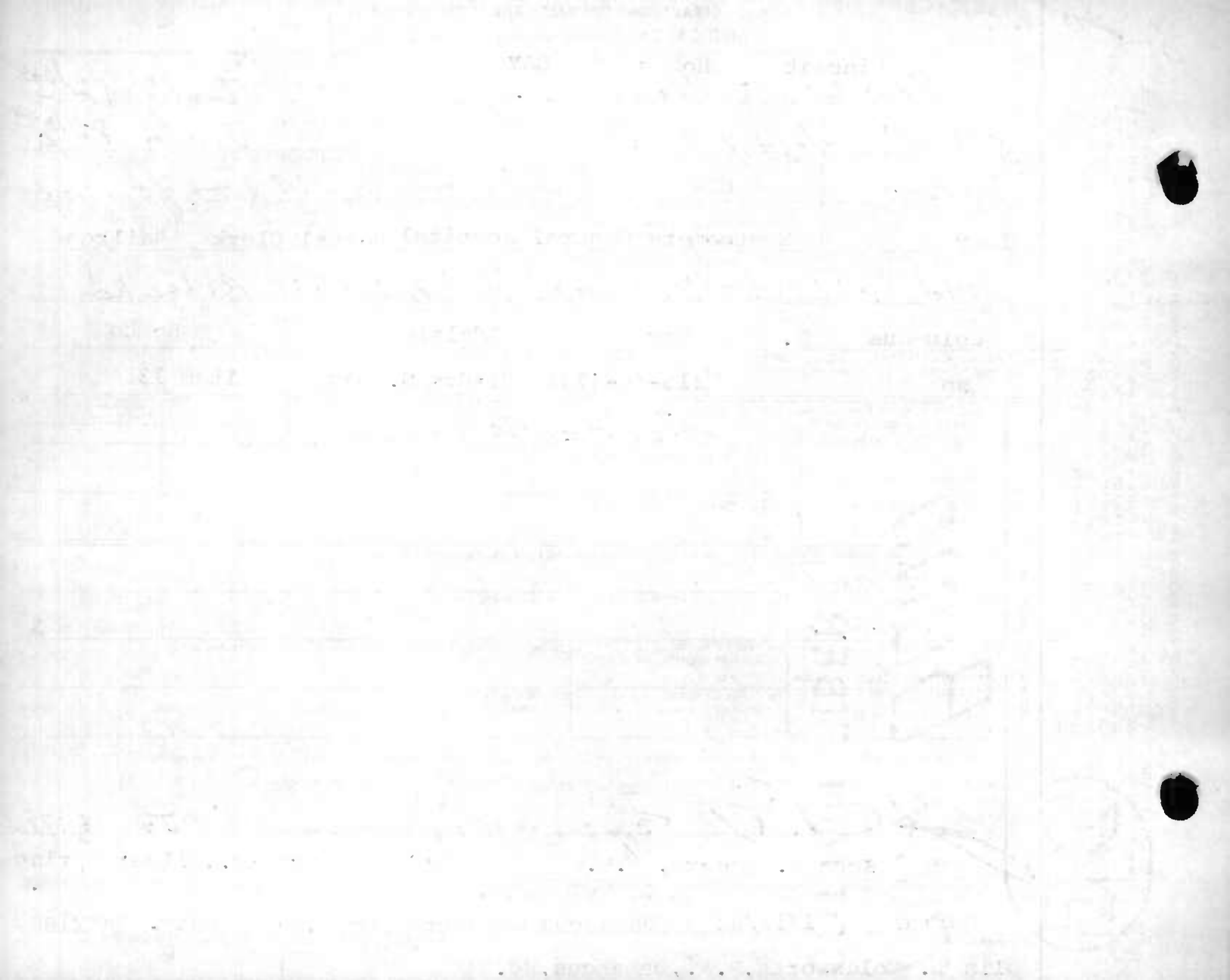
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
<b>None</b>			
19a. DATE OF OPERATION <b>None</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>1919 Seminary Rd., Silver Spring Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/19/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Damascus Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Damascus Montg. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, P.A.,</b>		ADDRESS <b>Damascus, Md.</b>	
25a. DATE OF REGISTRATION <b>Jan 16 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MARY VIRGINIA DELLINGER</b>		2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 1 YEAR 4 1982		2b. HOUR 11:05 P.M.	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH 12 DAY 28 YEAR 1903	6. AGE IN YEARS LAST BIRTHDAY 78 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Tak Park, Calverton, Advant. Hosp.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>Bel Air, George Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MACEY MIDDLE REDDISH LAST		15. MOTHER'S MAIDEN NAME FIRST ANNA MIDDLE GERTRUDE LAST GRIFFIN		12b. KIND OF BUSINESS OR INDUSTRY <b>JUSTICE DEPT.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>521-10-9707</b>		17. INFORMANT <b>FRANCES KAY DELLINGER SAME AS 13 DAUGHTER</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4409 Acute Myocardial Dis</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>Generalized Arteriosclerosis 4 yrs.</b> (b) <b>Generalized Arteriosclerosis 4 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D. Dep.</b>		MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b>		23e. COUNTY <b>MONT</b>	
24. FUNERAL DIRECTOR ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>	

MD.

DAUGHTER

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

YES ☐ NO ☒

CITY OR TOWN

COUNTY

STATE

Inquiry ☐

and in my opinion

Undetermined manner ☐.

DATE SIGNED

Jan 5 1982

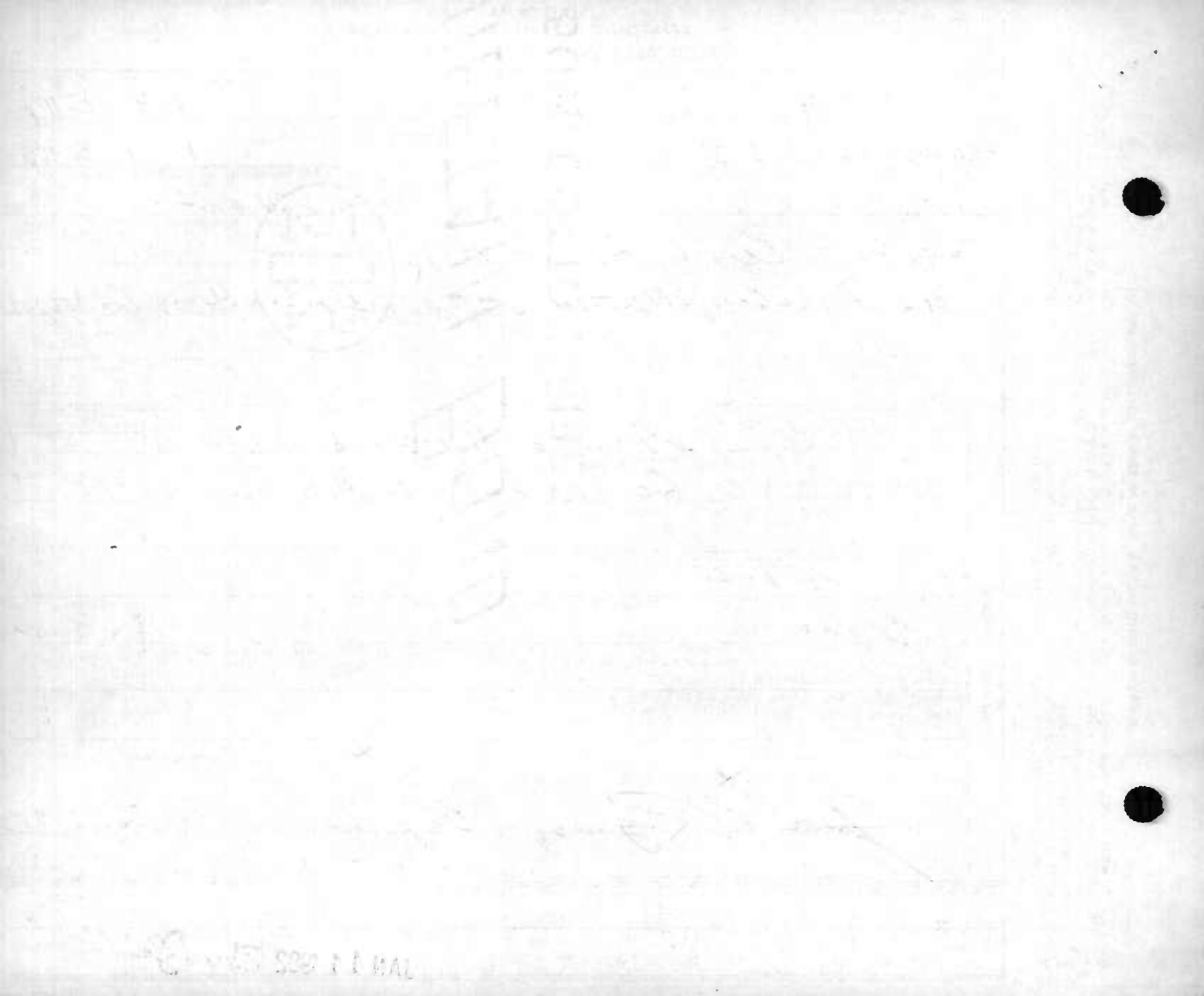
CITY OR TOWN

COUNTY

STATE

MD.





FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 1 2 9	
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR
Beatrice J. Dent			JAN. 15, 1982		
3. SEX Female			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		
4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR FEB 18, 1900		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH TAKOMA PARK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY PR. GEO		
13c. CITY OR TOWN UNIVERSITY PARK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 4213 WOODBERRY ST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET A		
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W. JONES			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N		
16b. SOCIAL SECURITY NO. 217-36-8062			17. INFORMANT ADDRESS JANET WIEBLER, 4213 WOODBERRY ST.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>0119</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Thoracoplasty - Tuberculosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5-6 days</u> <u>Years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive Heart Failure</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>MAY 1962</u> to <u>JAN 15, 1982</u> , that (I) (we) last saw the deceased alive on <u>JAN 15, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.			
22b. SIGNATURE <u>Robert B. Irel</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1-15-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT B. IREL</u>		22e. ADDRESS <u>11161 New Hamp. Ave., S. S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>JAN. 16, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CREMATORY</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>BRENTWOOD P.G. MD</u>		24. FUNERAL DIRECTOR NAME ADDRESS <u>Takoma Funeral Home, 254 Carroll St. N. W. D. C.</u>			
25a. DATE REC'D. BY REGISTRAR <u>JAN 19 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Van Houten</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called for aut.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR		REG. NO. 8 2 0 2 1 3 0								
1 DECEASED NAME (TYPE OR PRINT) Cesare DiBenedetto					2a DATE OF DEATH MONTH DAY YEAR JAN 22 1982 4 a.m.					
3 SEX MALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR AUG 16, 1927		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.		7b IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9732 GLEN AVENUE				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEPUTY MARSHALL		12b. KIND OF BUSINESS OR INDUSTRY JUSTICE DEPT.		
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING			
14 FATHER'S NAME FIRST MIDDLE LAST MATTEO DiBENEDETTO					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIA DiMARCO					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17 INFORMANT NORMA J. DiBENEDETTO		ADDRESS SAME AS 13 WIFE				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of colon &amp; kidney</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Approximate interval between onset and death: <u>4 years</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia Heart Disease with intubation</u>										
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a I certify that (I) (this hospital) attended the deceased from <u>January 20, 1982</u> to <u>January 22, 1982</u> , that (I) (we) last saw the deceased alive on <u>January 20, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Blaine H. Eig</u> M.D.				DEGREE M.D.			22c. DATE SIGNED Jan 22, 1982		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BLAINE H. EIG				22e. ADDRESS 9801 George A. C. Delaney, Ind 20902						
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/25/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.				
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 27 1982		25b. REGISTRAR'S SIGNATURE Francis Jean Nathan				

0. 4. 19. 11. 1947

10. 11. 1947



10. 11. 1947



10. 11. 1947

10. 11. 1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

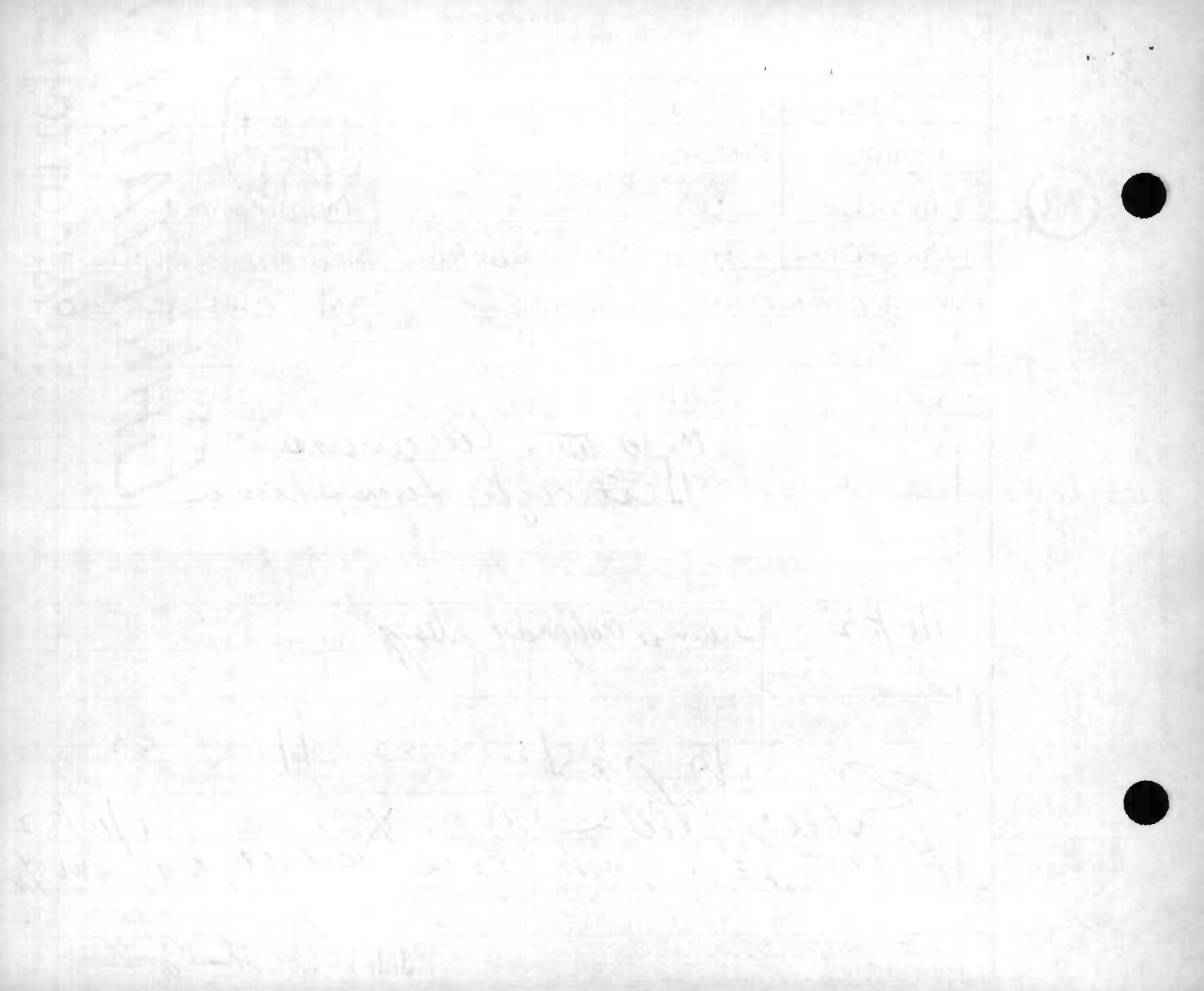
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 2 0 2 1 3 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY H. DIEPENBROCK</b>			2a. DATE OF DEATH MONTH <b>01</b> DAY <b>10</b> YEAR <b>82</b>			2b. HOUR <b>34</b> M					
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>16</b> YEAR <b>05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISSOURI</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>AMERICAN RED CROSS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>VOLUNTEER</b>			
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3342 CHISWICK COURT</b>	
14. FATHER'S NAME FIRST <b>WILLIAM</b> MIDDLE <b>J.</b> LAST <b>HEALY</b>				15. MOTHER'S MAIDEN NAME FIRST <b>CHARLOTTE</b> MIDDLE <b>OFFERMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>487-12-4430</b>		17. INFORMANT <b>ROY G. DIEPENBROCK</b>				ADDRESS <b>SAME AS 13 HUSBAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>2000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lymphocytic Lymphoma</b> (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b></b>											
19a. DATE OF OPERATION <b>1/5/82</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Drainage malignant pleural</b>				AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		70b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1/9/82</b> to <b>1/10/82</b> , that (I) (we) last saw the deceased alive on <b>1/9/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Barry J. Kevin, MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/10/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY J. KEVIN, MD</b>				22e. ADDRESS <b>1234-19th ST, N.W. - WASH, D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN <b>SILVER SPRING</b> COUNTY <b>MONT</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>					
						25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>					



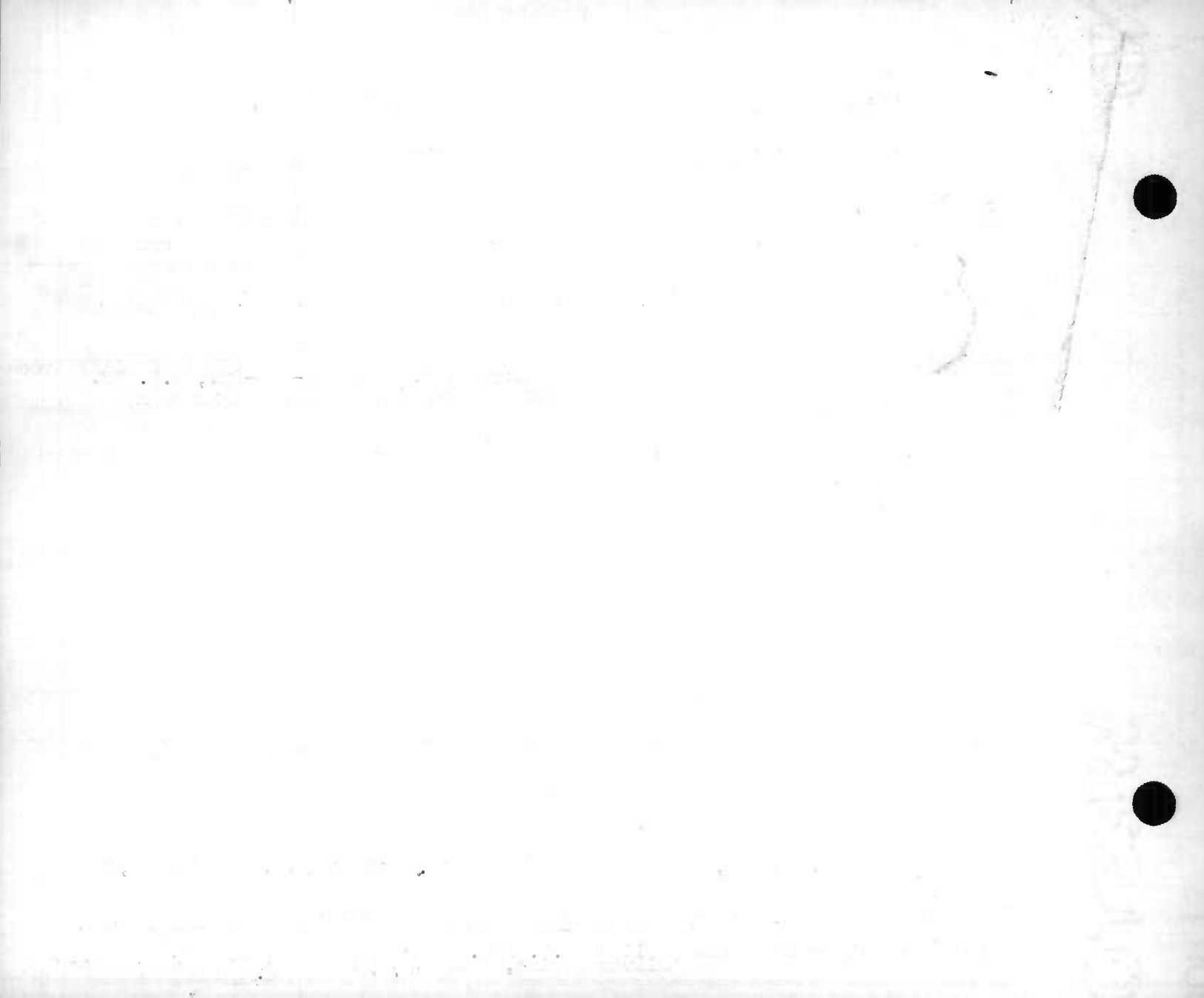


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Emilie C. Doehrer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 6, 1982</b>		2b. HOUR <b>5:45 p.m.</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 16 1909</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Lutheran Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Sp.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3367 S. Leisure Blvd.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Coyner</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Mary Kelly</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO <b>215462038</b>		17. INFORMANT <b>Patricia D. Rodeffer-Dau-Dr., S.S. Md.</b> ADDRESS <b>13905 Rippling Brook</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>amyotrophic lateral sclerosis</b> <b>3352</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>February 2, 1981</b> to <b>Jan 6, 1982</b> , that (I) (we) lost saw the deceased alive on <b>Jan 5, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE <b>Harold F. McCann M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-6-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Harold F. McCann, MD.</b>				22e. ADDRESS <b>3355 16th. Street, N.W. Washington, D</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-11-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Pr. Georges Md.</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>				ADDRESS <b>11800 N.H. Ave. Silver Spring, Md.</b>		25. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>Frances Jan...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ann M. Donnelly			2a. DATE OF DEATH MONTH DAY YEAR January 12, 1982			2b. HOUR 9:15 A M				
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 30, 1903		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Brooklyn, N.Y.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9922 Julliard Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beauty Culture Commissioner of N.J.		12b. KIND OF BUSINESS OR INDUSTRY Beauty Culture		
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9922 Julliard Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick J. Donohue			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary L. Ackerman							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 125-18-9270A		17 INFORMANT 9922 Julliard Drive, Bethesda Md. Mary Louise Doneski					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adeno Carcinoma - undifferentiated 1991 DUE TO, OR AS A CONSEQUENCE OF (b) Metastases to liver, peritoneum DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months. 8 months.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 2/12/81 to 1/12/82, that (I) (we) lost the deceased alive on 1/12/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if deceased (did not) die the body after death.										
22b. SIGNATURE OF PHYSICIAN J. Blaine Fitzgerald, M.D.						22c. DATE SIGNED Jan. 12, 1982		22d. ADDRESS 8218 Wisconsin Ave., Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 16, 1982		23c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre		23d. LOCATION CITY OR TOWN COUNTY STATE E. Orange N.J.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey						25a. DATE REC'D. BY REGISTRAR JAN 18 1982				



MOTION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Dixon</i>				MIDDLE				LAST <i>Donnelley</i>				2a. DATE KNOWN OF DEATH				2b. HOUR					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 29, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD <b>Jan 6 1982</b>				2d. HOUR <b>11:45 AM</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD													
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6215 Goldsborough Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>													
13a. STATE <b>Maryland</b>												13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6215 Goldsboro Rd.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Donnelley</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Dixon</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>121-03-4278</b>				17. INFORMANT <b>Lucia S. Donnelley</b>				ADDRESS <b>6215 Goldsboro Rd.</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wound of Head.</b> <b>9552</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Salt inflicted -</b> (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>1:45 AM 1-6 1982</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <b>Shot self in chin. C-35 cal. Rifle.</b>																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6215 Goldsborough Rd Bethesda Montgomery Md</b>																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																									
ACTUAL SIGNATURE <i>John S. Ball</i>				TITLE (SPECIFY) <b>M.D. Deputy</b> MEDICAL EXAMINER																					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>1-6-82</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Med. School</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>													
24. FUNERAL DIRECTOR NAME ADDRESS <b>Metropolitan Funeral Service, Alexandria, Va.</b>												25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>											



Male	White	July 20, 1912	66
New York	U.S.A.		
Retired	U.S. Govt.		
Maryland	Montgomery	Bethesda	x
Patrick	Donnelly	Katherine	Nixon
Yes	121-13-4278	India S. Donnelly 5213 Goldsboro Rd.	

Neurological Hospital Service, Alexandria, Va.  
1-6-82  
Georgetown Med. School  
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) <b>CLYDE WILLIAM DOVE</b> <i>Clyde W. Dove</i>					2a. DATE OF DEATH MONTH <b>JAN.</b> DAY <b>13</b> YEAR <b>82</b>			2b. HOUR <b>1:55 PM</b> <b>1355 M</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>OCT.</b> DAY <b>3</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.						
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MAINT. FOREMAN</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.GOV.</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>GAITHERSBURG</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11830 Marmary Road</b>				
14. FATHER'S NAME FIRST <b>ABLE</b> MIDDLE <b>THEODORE</b> LAST <b>DOVE</b>					15. MOTHER'S MAIDEN NAME FIRST <b>MARTHA</b> MIDDLE <b>E.</b> LAST <b>MILLER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>					16b. DATE OF SERVICE <b>1972-1979</b>		17. INFORMANT <b>Lindell Dove</b>		ADDRESS <b>Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4029 Intracerebral Congestive Asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertensive Cardio-vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>7 cigarettes Mellitus Hypertension</b>												
19a. DATE OF OPERATION <b></b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b>19</b> <b>P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b></b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>						
22a. I certify that (I) (the hospital) attended the deceased from <b>Sept 19 50</b> to <b>Jan 13 82</b> that (I) (we) last saw the deceased alive on <b>13 Jan 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.												
22b. SIGNATURE <i>John C. Fawcett</i>						DEGREE <b></b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/14/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN C. FAWCETT M.D.</b>						22e. ADDRESS <b>16610 Sugarland Rd. Dawsonville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>Jan. 17, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Cem.</b>			23d. LOCATION CITY OR TOWN <b>Baker</b> COUNTY <b>Hardy</b> STATE <b>West Va.</b>				
24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

MEDICAL CERTIFICATION





MAILED

RECEIVED

1910

1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 3 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Katherine E Dronenburg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 3 1982</b>			2b. HOUR <b>7<sup>10</sup> PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 27 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Schools</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>211 N. Van Buren Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Magruder</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ricketts Sarah Harding</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					
		16b. SOCIAL SECURITY NO. <b>218-24-0876</b>		17. INFORMANT ADDRESS <b>Charles W. Dronenburg, Alexandria Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardiovascular disease</b> 30 years DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic congestive heart failure</b> 15 years								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1 1981</b> to <b>1/3 1982</b> that (I) (we) last saw the deceased alive on <b>1/3 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. G. Hall</b>				22c. DATE SIGNED <b>1/3/82</b>				22d. ADDRESS <b>615 West Montgomery Ave. Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 6, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Ch. Cem. Clarksburg</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>		23e. NAME OF FUNERAL HOME <b>Robert A. Pumphery Funeral Homes, P.A. Rockville, Maryland</b>	
23f. DATE REC'D. BY REGISTRAR				23g. REGISTRAR'S SIGNATURE <b>JAN 11 1982 James J. Nathan</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this fact.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 3 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Katherine A. DUNCAN</b>				2b. DATE OF DEATH MONTH DAY YEAR 1-9-82			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 9, 1912</b>		2b. HOUR <b>1:45 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WEST VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>WHEATON</b>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WHEATON MANOR CARE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FINANCE CLERK</b>			
12b. KIND OF BUSINESS OR INDUSTRY <b>HOSPITAL</b>							
13a. STATE <b>MARYLAND</b>				13b. CITY OR TOWN <b>MONTGOMERY</b>			
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13d. STREET ADDRESS <b>7111 GILBERT PLACE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ZEDDOCK P. HAMMER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GAY JEWELL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>235-18-4914</b>			
17. INFORMANT <b>BROTHER</b>				ADDRESS <b>216 E 3RD STREET WESTON, W. VIRGINIA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung with metastasis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>1629</b> (c) <b>4 months</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Obstructive Pulmonary Disease, Compensated Heart Failure.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>69</b> , to <b>January 9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Dec. 28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Hugo G. Braziani</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-9-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUGO G. BRAZIANI M.D.</b>				22e. ADDRESS <b>800 PERSHING DR. 303A S.S. MD - 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON VIRGINIA</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>			
25b. ADDRESS <b>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</b>				25c. REGISTRAR'S SIGNATURE <b>James J. Hester</b>			





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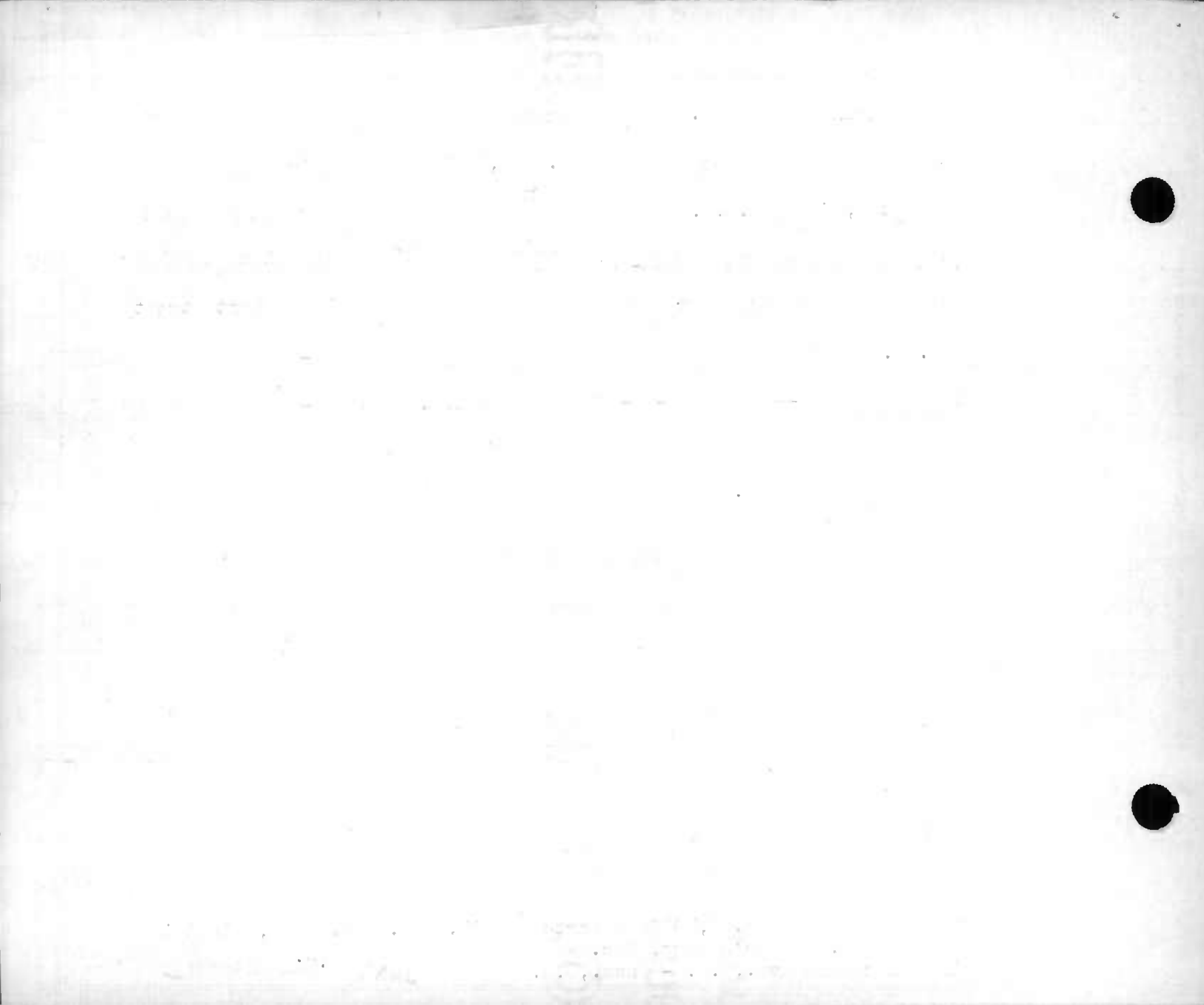
TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 2 1 3 9	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH	
			FIRST MIDDLE LAST Beulah K. Eastburn		MONTH DAY YEAR January 4-1982	
3 SEX Female			4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1897	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 84 YRS	
10 CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARRIAGE HILL-BETHESDA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian	
13a. STATE Maryland			13b. CITY OR TOWN Sumner		13c. STREET ADDRESS 5110 Nahant Street	
14 FATHER'S NAME FIRST MIDDLE LAST U. S. GRANT KENDRICK			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE COPPERSMITH		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No	
17 INFORMANT ADDRESS Adelbert C. Eastburn-Address same as #13 above			18 SOCIAL SECURITY NO. 578-62-2825		19. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>January 19, 81</u> to <u>January 7, 1982</u> , that (I) <u>last</u> saw the deceased alive on <u>12/15/81</u> 19 <u>81</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did not</u> view the body after death.						
22b. SIGNATURE <u>James W. Egan M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Jan. 4/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James W. Egan</u>		22e. ADDRESS <u>5413 Cedar Lane - Bethesda Md</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Ft. Myer, Virginia
24 FUNERAL DIRECTOR NAME 5130 Wisconsin Ave., N.W. - Wash., D.C.				25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8202140	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MARY Beulah EICHNER</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1/21/82</i>		2b. HOUR <i>11:15/AM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 10, 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Office Worker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>			
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8507 Garland Avenue</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Hunter Files</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Virginia Zeilor</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>543-07-4236</i>		17. INFORMANT <i>Dorothy E. Vaughn</i> <i>8507 Garland Avenue</i> <i>Takoma Park, MD 20914</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>possible pulmonary embolism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pneumonia</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>1/19/82</i> , 19____, to <i>1/21/82</i> , 19____, that (I) (we) last saw the deceased alive on <i>1/20</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Smith S. Ho, M.D.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/25/82</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SMITH S. HO, M.D.</i>				22e. ADDRESS <i>8323 Haddon DR. Takoma Park Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Jan. 27, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick County, Virginia</i>					
24. FUNERAL DIRECTOR NAME <i>George E. Tolman</i> ADDRESS <i>Winchester, Va.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 29 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James D. Miller</i>					



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		Mathilde Eiker		CERTIFICATE OF DEATH		REG. NO. 8202141			
1. DECEASED NAME (TYPE OR PRINT) <b>MATHILDE EIKER</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 25 82</b>		2b. HOUR <b>1:15 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 5, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Writer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Author</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>None</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3914 - 49th St. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Eiker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mattie Ethridge</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-62-2125</b>		17. INFORMANT ADDRESS <b>Taylor Eiker 4949 Battery La. Ch.Ch., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b> (b) <b>Arteriosclerotic Heart Dis</b> (c) <b>Arteriosclerosis</b> <b>3 have years years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>malnutrition</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE) <b>1125 F St. N.W. Wash. D.C.</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 21, 1982</b> to <b>1/25/82</b> , that (I) (we) last saw the deceased alive on <b>1/25/82</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Thos G. Ward M.D.</b>		22c. DATE SIGNED <b>1/25/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD 4116 ROBINWOOD Bethesda, Md 20819</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <b>Wash. D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>		24b. ADDRESS <b>5130 Wis. Ave. N.W. Wash., D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1982</b>		25b. REGISTRAR SIGNATURE <b>Thos G. Ward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JAN 28 1952

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JAN 28 1952

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 4 2

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>LAUREL LEE ELBRADER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1.13.82</b>			2b. HOUR <b>3.25 PM</b>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 2 1910</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>71</b>		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KANSAS</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10 CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COMMUNICATIONS</b>		12b KIND OF BUSINESS OR INDUSTRY <b>EXP. DEPT OF DE</b>		
13a STATE <b>MARYLAND</b>			13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>SILVER SPRING</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>15301 WALLBROOK COURT</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>FRANK ELBRADER</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BERTHA BURCKHARDT</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>NO</b>			16b SOCIAL SECURITY NO. <b>516-07-0622</b>		17 INFORMANT ADDRESS <b>MARY FRANCES ELBRADER SAME AS 13 WIFE</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE CARDIAC &amp; RESPIRATORY ARREST</b> <b>5850</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ANEMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC RENAL FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>3 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PROBABLE AMYLOIDOSIS, RHEUMATOID ARTHRITIS, COPD, GIBBLETS, SEIZURES</b>										
19a DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <b>12-28</b> , 19 <b>81</b> , to <b>1-13</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>1-13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Oliver J. Lawless</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1.13.82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OLIVER J. LAWLESS MD.</b>			22e ADDRESS <b>Suite 323, P.O. Building, Montgomery, Maryland</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/16/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>			
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>			ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b>			25b. REGISTRAR'S SIGNATURE <b>Frances Jan Keithen</b>	

MEDICAL CERTIFICATION





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202143			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOSEPH G. EL-HAJJ</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 29-82</b>			
3. SEX <b>Male</b>				4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 3-17</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO. MD.</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		12a. USUAL OCCUPATION (GIVE OR MOST OF WORKING LIFE) <b>Buyer-Manager</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George A. El-Hajj</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lizzie Nahass</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>197-18-9713</b>		17. INFORMANT ADDRESS <b>Mrs. Janina O. El-Hajj, Wife, Sam as item #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSELEBATIC HEART DIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MYS</b> <b>6 MYS</b> <b>2 YRS</b> <b>7 YRS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC 19 75</b> , to <b>JAN 29 19 82</b> , that (I) (we) host saw the deceased alive on <b>1/29 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Daniel Rosenblum</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/30/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL ROSENBLUM</b>				22e. ADDRESS <b>10400 CONNECTICUT AV KENSINGTON, MD 20895</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 5, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Janina O. El-Hajj</b>	

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Adele Elias				11/6/82 24 M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 4/15/1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Italy Cross Hospital of S.S.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Md.		13b. COUNTY Mtg. Co.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Ignatz Zierer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Bro		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 082-18-7321		17. INFORMANT Mae Shapiro (daughter)		ADDRESS 5302 Flanders Ave. Kensington, Md. 20895			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4292 Cardio-vascular heart				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular disease				DUE TO, OR AS A CONSEQUENCE OF			
(c)				DUE TO, OR AS A CONSEQUENCE OF			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from May 21, 1981 to June 6, 1982, that (II) (we) last saw the deceased alive on May 21, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN		DEGREE MD		ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-6-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Furman		22e. ADDRESS 3720 Vantage Ave. Ken. Md. 20895					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/7/82		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.	
24. FUNERAL DIRECTOR 1170 Rockville Pk., Rockville, Md. DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 12 1982 Frances Jean Nathan			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				8 2 0 2 1 4 5			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph Charles Engers</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 18, 1982</b>		2b. HOUR <b>3 30 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 18, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>75 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3915 Oliver Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>General Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Meat Bus.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Engers</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Streb</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>562-12-1505</b>		17. INFORMANT ADDRESS <b>Wife - Theresa C. Engers - Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG (Left)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Emphysema of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>79</b> , to <b>JAN. 18</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>JAN. 18</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George A. Boinis M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 18, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George A. Boinis, M.D.</b>				22e. ADDRESS <b>5410 Conn. Ave., N.W., Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 21, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Mont., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

MEDICAL CERTIFICATION

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George A. Bordin, M.D.  
4110 Conn. Ave., N.W., Wash. D.C.  
Funeral Home  
1401 21st St., N.E., Wash. D.C.  
Silver Spring, Md.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 0 2 1 4 6	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MINNIE nmi EPSTEIN			2a. DATE OF DEATH Jan. 24, 1982		2b. HOUR 11 a.m.	
3 SEX Female		4 RACE White	5. DATE OF BIRTH Aug. 24, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper (Ret)		12b. KIND OF BUSINESS OR INDUSTRY Furn. Office
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spring	13d. STREET ADDRESS 1603 Parham Road		
14. FATHER'S NAME Leon Laserson			15. MOTHER'S MAIDEN NAME Viola Kolinsky			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 010-03-9551		17. INFORMANT ADDRESS Marion Froman; 1603 Parham Rd., Sil.Spg., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL METASTASES</u> 1727 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALIGNANT MELANOMA LEFT</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>LOWER EXTREMITY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 MOS.</u> <u>3 YRS</u>						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>1-24-82</u> to <u>1-24-82</u> , that (1) (we) last saw the deceased alive on <u>1-24-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.						
22a. SIGNATURE OF PHYSICIAN <u>Joel A. Reiskin</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <u>1-24-82</u>
22c. PHYSICIAN'S NAME (TYPE OR PRINT) JOEL A. REISKIN, M.D.				22d. ADDRESS 809 Viers Mill Road; Rockville, Md., 20851		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-26-1982		23c. NAME OF CEMETERY OR CREMATORY Sharon Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Brookline, Massachusetts
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR JAN 27 1982		25b. REGISTRAR'S SIGNATURE <u>James V. K...</u>



4-10-81  
Sms

Handwritten notes in the center of the page, possibly a list or a short paragraph.

1-24-81  
Handwritten signature or name at the bottom left.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the funeral director to retain the body.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 4 7			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT FRANKLIN EYLER</b>				2a. DATE OF DEATH MONTH DAY YEAR 01 02 82			
3 SEX <b>MALE</b>				2b. HOUR 1153 AM			
4 RACE <b>W/cauc.</b>		5 AGE (IN YEARS LAST BIRTHDAY) 55		6 IF UNDER 1 YEAR MONTHS DAYS		7 IF UNDER 24 HRS. HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9a. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9b. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>		10. CITY OR TOWN OF DEATH <b>Rockville</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hsp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Driller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Cement Plant</b>		13. STATE <b>Maryland</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mervin E. Eyer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Viola - - Johnson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes World War II</b>		16b. SOCIAL SECURITY NO. <b>215326971</b>	
17. INFORMANT <b>Bonnie J. Eyer, Westminster, Md.</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HYPERKALEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>		19. DATE OF OPERATION	
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 2</b> 19 <b>81</b> to <b>JAN 2</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>JAN 2</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Stephen M. Hellman</b>		22c. ADDRESS <b>14805 PHYSICIANS LA Rockville, Md 20850</b>		22d. DATE SIGNED <b>1/2/82</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll County, Md.</b>	
24. FUNERAL DIRECTOR <b>D.W. Hartzler</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>		25c. ADDRESS <b>Union Bridge, Md.</b>	



Handwritten notes and signatures, including the name "Stephen M. [illegible]" and dates like "JUL 2 1961".

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Sylvia		Fairberg		1-29 1982		AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD	10. MONTH DAY YEAR
Female	White	09 13 09	72 YRS.			January 29 82	8 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	U. S. A.		WIDOWED		Montgomery		MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville	11050 Rockville Pike #614			Administration		Office	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Rockville	YES	11050 Rockville Pike #614			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Alter		Katz		Blima			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		N/A		Daughter			
		088-10-6915		Barbara Kahn Bethesda Md. 20817			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4039							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:							
(b)							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
John A. Ball		M.D. Dep				1-30-82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
John Ball		7936 Old Georgetown Rd.		Beth. Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Burial	Feb 1 82	Wellwood Cemetery		Pinelawn		Suffolk N.Y.	
24. MEDICAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey		Box 7428		FEB 3 1982		Name Jan Ball	
		Sil. Spr. Md. 20907					

MEDICAL CERTIFICATION

4401



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8202149

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN G. FALLON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 16 82</b>			2b. HOUR <b>5:35 A M</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 9 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BROOKE GROVE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>OLNEY</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3226 SPARTAN RD.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM E. GOSNEAR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE R. ROONEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF NOT, UNKNOWN)			16b. SOCIAL SECURITY NO. <b>163-50-2222</b>		17. INFORMANT <b>WILLIAM I, FALLON</b>				ADDRESS <b>SAME AS 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4370</b> IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>many years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic congestive heart failure</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>81</b> , to <b>16 Jan</b> , 19 <b>82</b> , that (I) <del>was</del> lost saw the deceased alive on <b>23 Dec</b> , 19 <b>81</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.										
22b. SIGNATURE <b>Donald E. Dillon MD</b>			DEGREE			22c. DATE SIGNED <b>16 Jan 82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald E. Dillon, M.D.</b>			22e. ADDRESS <b>18111 P. Philip Dr Olney, Md 20832</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>JAN. 17, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREM. SILVER SPRING, MD</b>		23d. LOCATION <b>ALEXANDRIA</b> COUNTY <b>VA</b> STATE			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS 500 UNIV. BLVD. WEST,</b>						25a. DATE REG. BY REGISTRAR <b>JAN 21 1982</b> REGISTRAR'S SIGNATURE <b>Charles J. Keith</b>				

MEDICAL CERTIFICATION

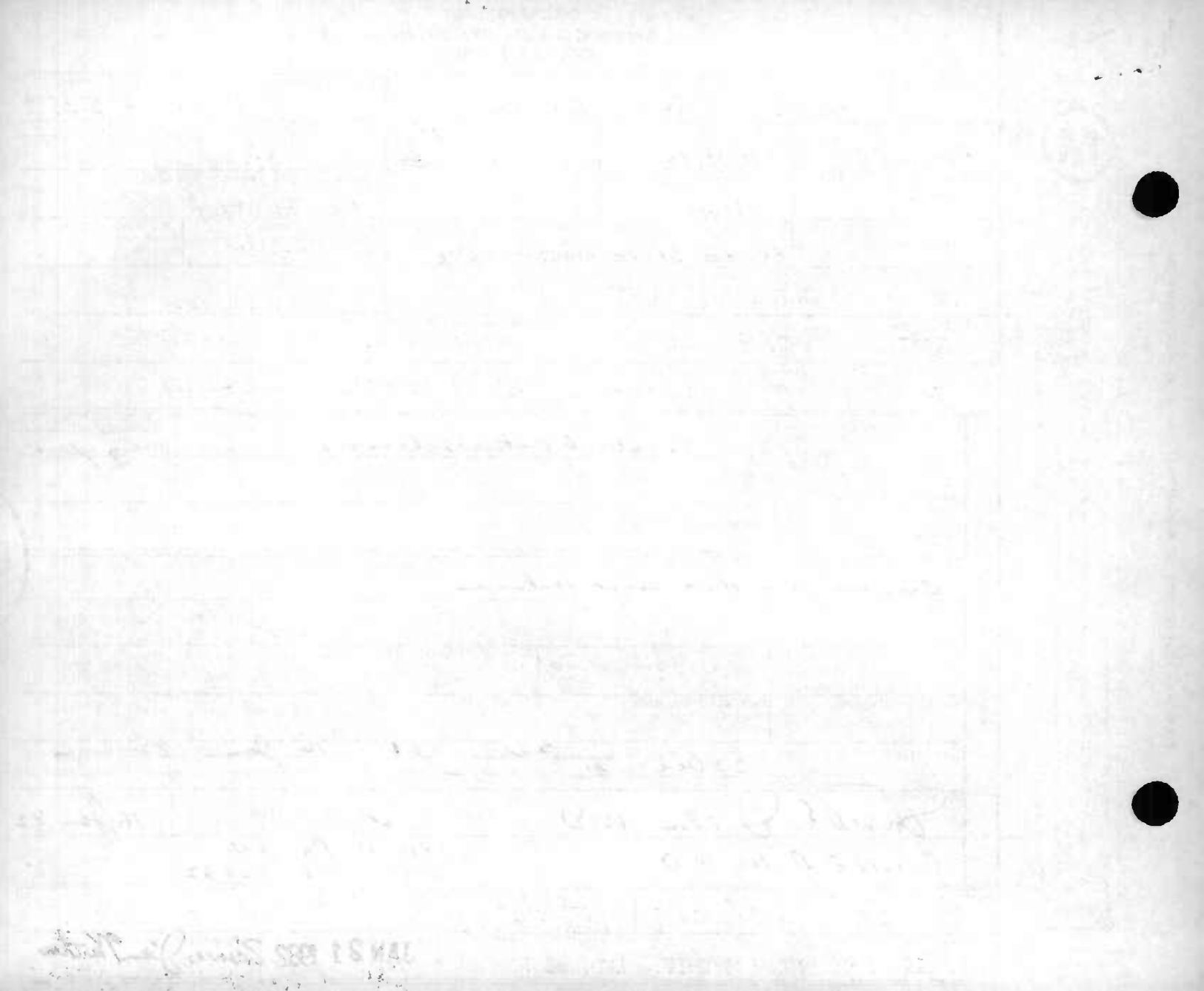
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1301

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Francis Farrar</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN. 20 82</b>			2b. HOUR <b>10:12a<sub>M</sub></b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 3, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUILDER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
13a. STATE <b>MARYLAND</b>			13b. CITY OR TOWN <b>MONT. SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>15301 Baughman Dr.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>George - Farrar</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katinka - Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-01-2414</b>		17. INFORMANT ADDRESS <b>Esther Farrar Same as #13</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 4310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>GRAM NEGATIVE SEPSIS</b>									
19a. DATE OF OPERATION <b>2/9</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>1/11</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>82</b> , to <b>1/21</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/20/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Raymond Bass</b> DEGREE <b>MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/20/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAYMOND BASS</b>				22e. ADDRESS <b>3929 Ferrara Dr Wheaton 20906</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>Jan. 21, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b>				ADDRESS <b>Laytonsville, Md. 20879</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Monica J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

29

3205

BP

1944

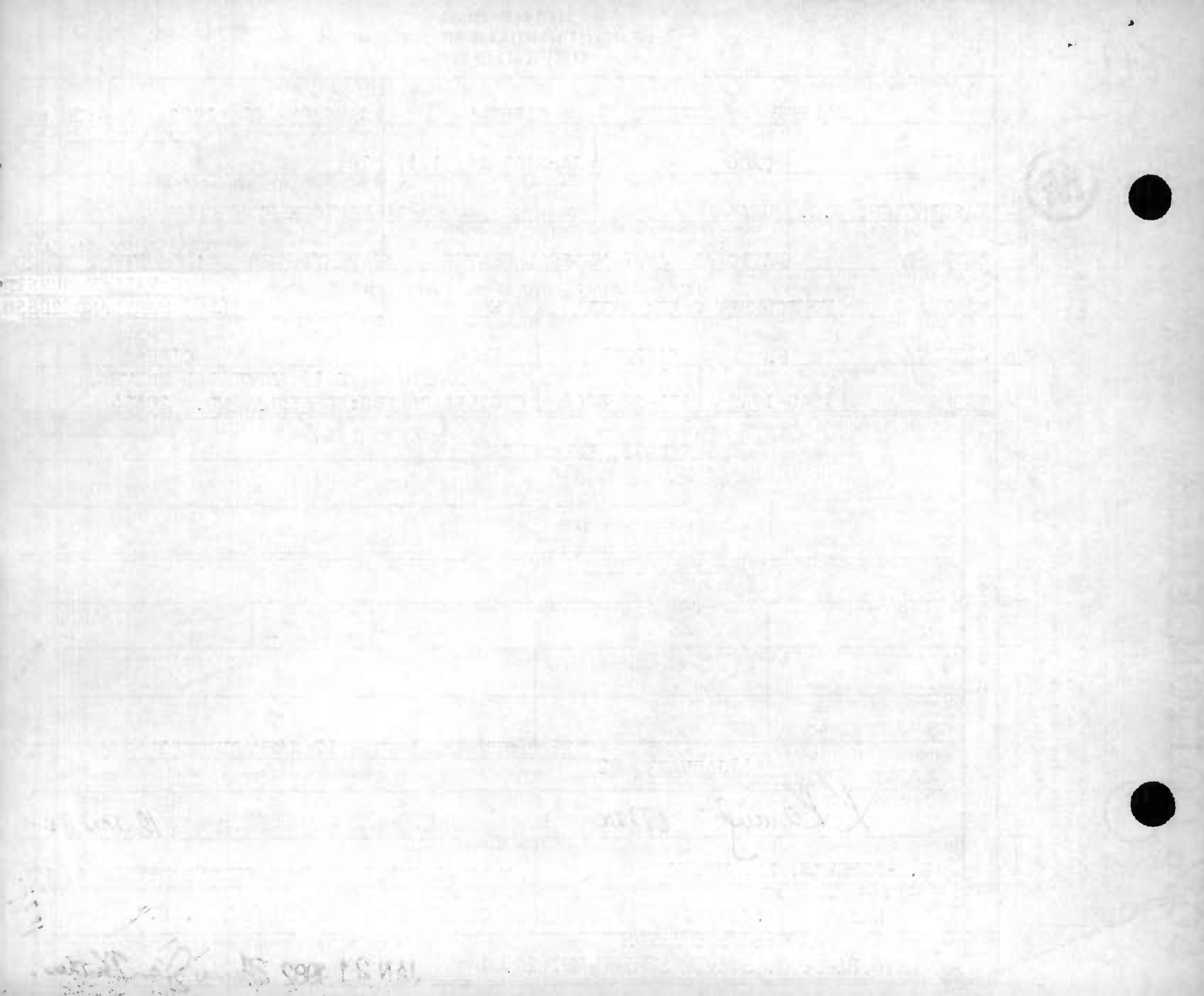


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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 2 0 2 1 5 1

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			
ALBERT		BERNARD	FARRELL		JANUARY 17, 1982		4:20 p.m.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE	CAUC	MONTH DAY YEAR JANUARY 26, 1911		70		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.	USA			MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	NATIONAL NAVAL MEDICAL CENTER			INVESTIGATOR		D.C. CONTROL BOARD	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS			
MARYLAND	MONTGOMERY		CHEVY CHASE ROCKVILLE		4900 BAYARD BLVD., CHEVY CHASE, MD.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		17. INFORMANT			
FIRST MIDDLE LAST ALBERT B. FARRELL		FIRST MIDDLE LAST ELLEN O'DEA		COUSIN 9819 SINGLETON DRIVE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		1940-1945 577-24-8805		CECILIA ROUNDS: BETHESDA, MD. 20034			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS, PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>25 DECEMBER 81</u> to <u>17 JANUARY 82</u> , that (I) (we) last saw the deceased alive on <u>17 JANUARY 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
<i>L. Karvelis</i>		LTMC				18 JAN 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
K. KARVELIS, LT, MC, USN R		NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		1/20/82		MT. OLIVET CEMETERY		WASHINGTON, D.C. STATE	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FRANCIS J. COLLINS		JAN 21 1982		<i>Francis J. Collins</i>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

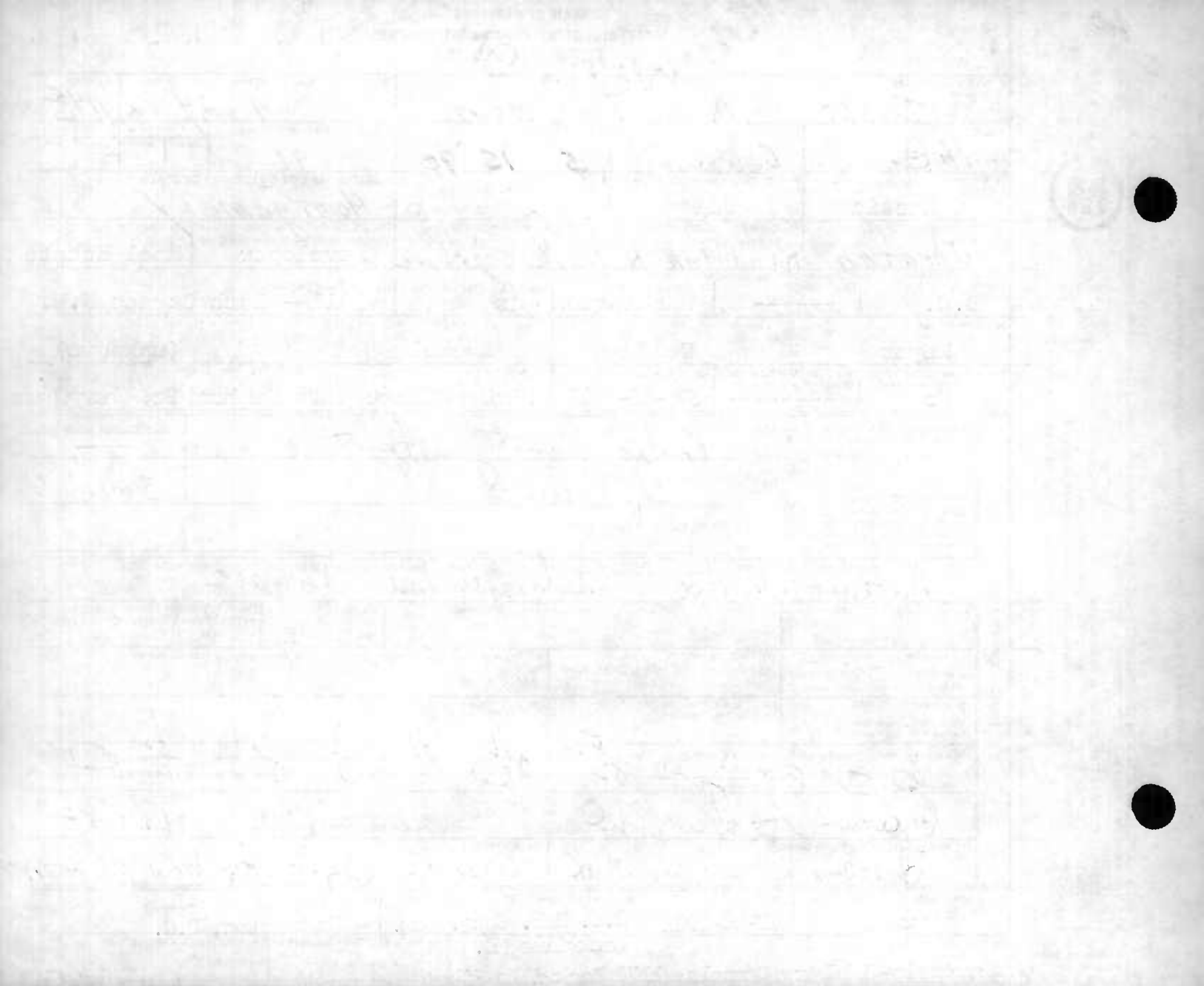
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 0 2 1 5 2				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Issac M. Feldman</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1 24 82</i>				2b. HOUR <i>11:45</i> M	
3 SEX <i>Male</i>		4 RACE <i>Caucasian</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>5 15 90</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS		6 UNDER 1 YEAR MONTHS DAYS <i>11 45</i> HRS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.			
10 CITY OR TOWN OF DEATH <i>Wheaton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Randolph Hills Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Developer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>D.C.</i>		13b. COUNTY <i>-----</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7411 - 14th Street N.W.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Meyer Feldman</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ruchel (unknown)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-10-1125</i>		17. INFORMANT ADDRESS <i>Md. Miriam Gilbert; 3404 Shepherd St; Chevy Chase</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Cardio-Respiratory Arrest</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Septicemia</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i>-----</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Antenatal infection, Cardiovascular Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>February 20, 1981</i> to <i>January 24, 1982</i> , that (I) (we) last saw the deceased alive on <i>January 20, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <i>Benjamin Aronovitch, MD</i>				DEGREE				22c. DATE SIGNED <i>1-24-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Benjamin Aronovitch, MD</i>				22e. ADDRESS <i>3720 Franchot Ave. N.W. Md 20511</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-26-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>S.E. Heb. Cong. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>			
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels; 1170 Rockville Pike</i>				ADDRESS <i>Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 27 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 1 5 3				
1. FOR STATE REGISTRAR		REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	a
RUTH		FELDMAN						Jan. 18, 1982					11:10	M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		Aug. 16, 1903		78 YRS.		MONTHS		DAYS		HOURS		MIN.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
New York		USA				Montgomery MD								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville		259 Congressional Lane								Housewife		-----		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		259 Congressional Lane						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST				FIRST MIDDLE LAST										
Leopold Menzer				Esther Schwartz										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17. INFORMANT								
No				572-72-0077		Gaithersburg, Md. Francine Albert; 11320 Brandy Hall La								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden death - prob. Cardiovascular collapse</u> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes.</u> <u>years</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Parkinson's disease</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) this hospital attended the deceased from <u>Dec. 22</u> 19 <u>81</u> , to <u>present (1/19/82)</u> the (I) (we) last saw the deceased alive on <u>1/13/82</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.														
22b. SIGNATURE		DEGREE								22c. DATE SIGNED				
<u>Sanford N. Richman, M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								1-19-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS												
SANFORD N. RICHMAN, M.D.		11500 Old Georgetown Rd; Rockville, Md												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		1-20-1982		Judean Mem. Gardens Olney, Maryland				Rockville, Md.						
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR												
NAME ADDRESS		JAN 22 1982												
Danzansky-Goldberg Chapels; 1170 Rockville Pike														

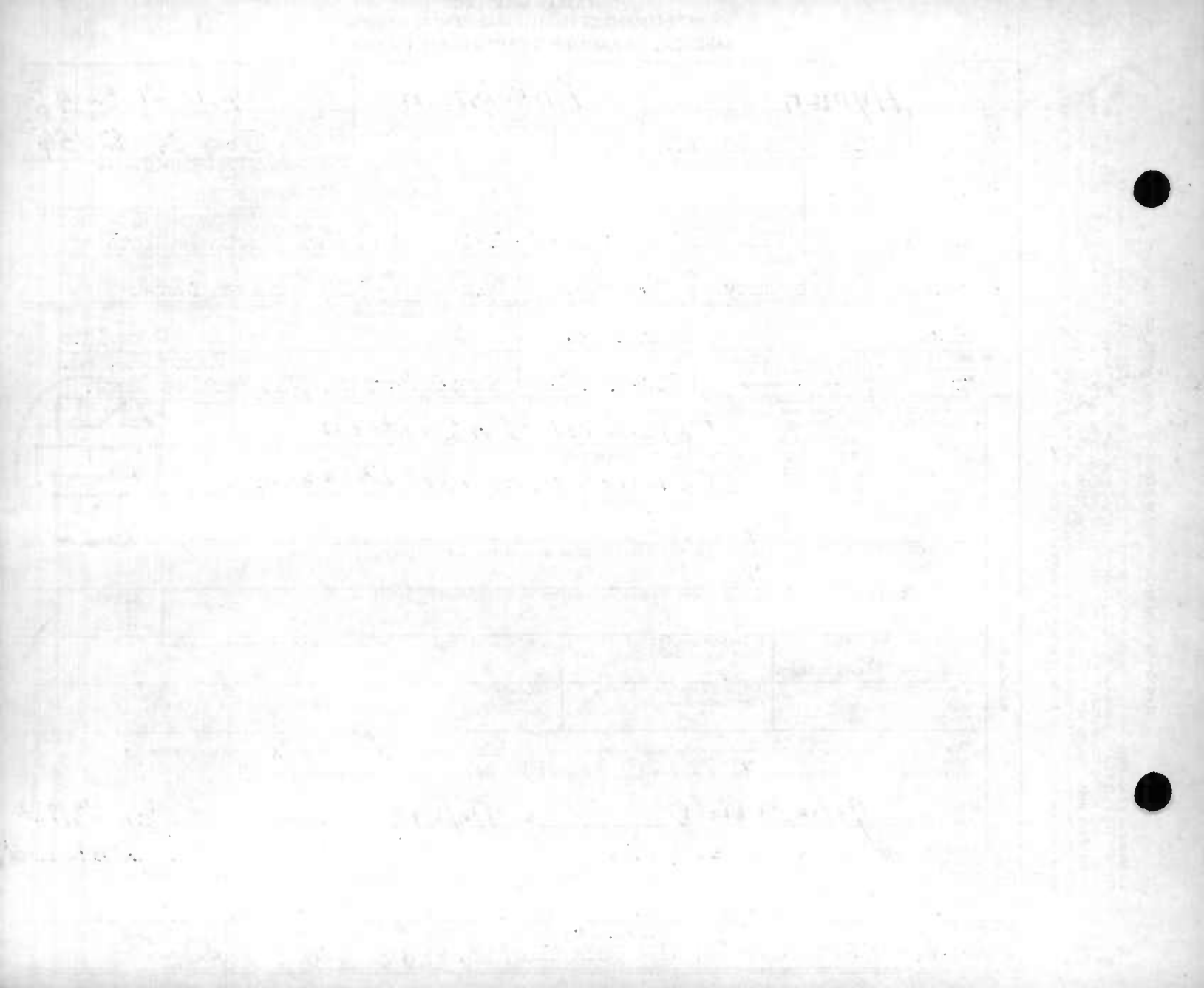
added death - Prob. Cardiovascular  
cause  
years

Garland's disease

Infant M. H. (1911) 82 - 85 - 88 - 91 - 94 - 97 - 100 - 103 - 106 - 109 - 112 - 115 - 118 - 121 - 124 - 127 - 130 - 133 - 136 - 139 - 142 - 145 - 148 - 151 - 154 - 157 - 160 - 163 - 166 - 169 - 172 - 175 - 178 - 181 - 184 - 187 - 190 - 193 - 196 - 199 - 202 - 205 - 208 - 211 - 214 - 217 - 220 - 223 - 226 - 229 - 232 - 235 - 238 - 241 - 244 - 247 - 250 - 253 - 256 - 259 - 262 - 265 - 268 - 271 - 274 - 277 - 280 - 283 - 286 - 289 - 292 - 295 - 298 - 301 - 304 - 307 - 310 - 313 - 316 - 319 - 322 - 325 - 328 - 331 - 334 - 337 - 340 - 343 - 346 - 349 - 352 - 355 - 358 - 361 - 364 - 367 - 370 - 373 - 376 - 379 - 382 - 385 - 388 - 391 - 394 - 397 - 400 - 403 - 406 - 409 - 412 - 415 - 418 - 421 - 424 - 427 - 430 - 433 - 436 - 439 - 442 - 445 - 448 - 451 - 454 - 457 - 460 - 463 - 466 - 469 - 472 - 475 - 478 - 481 - 484 - 487 - 490 - 493 - 496 - 499 - 502 - 505 - 508 - 511 - 514 - 517 - 520 - 523 - 526 - 529 - 532 - 535 - 538 - 541 - 544 - 547 - 550 - 553 - 556 - 559 - 562 - 565 - 568 - 571 - 574 - 577 - 580 - 583 - 586 - 589 - 592 - 595 - 598 - 601 - 604 - 607 - 610 - 613 - 616 - 619 - 622 - 625 - 628 - 631 - 634 - 637 - 640 - 643 - 646 - 649 - 652 - 655 - 658 - 661 - 664 - 667 - 670 - 673 - 676 - 679 - 682 - 685 - 688 - 691 - 694 - 697 - 700 - 703 - 706 - 709 - 712 - 715 - 718 - 721 - 724 - 727 - 730 - 733 - 736 - 739 - 742 - 745 - 748 - 751 - 754 - 757 - 760 - 763 - 766 - 769 - 772 - 775 - 778 - 781 - 784 - 787 - 790 - 793 - 796 - 799 - 802 - 805 - 808 - 811 - 814 - 817 - 820 - 823 - 826 - 829 - 832 - 835 - 838 - 841 - 844 - 847 - 850 - 853 - 856 - 859 - 862 - 865 - 868 - 871 - 874 - 877 - 880 - 883 - 886 - 889 - 892 - 895 - 898 - 901 - 904 - 907 - 910 - 913 - 916 - 919 - 922 - 925 - 928 - 931 - 934 - 937 - 940 - 943 - 946 - 949 - 952 - 955 - 958 - 961 - 964 - 967 - 970 - 973 - 976 - 979 - 982 - 985 - 988 - 991 - 994 - 997 - 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 8 2 0 2 1 5 4									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Hyman Finkelstein</i>									
2a. DATE KNOWN OF DEATH		MONTH DAY YEAR <i>1-29 1982</i>		2b. HOUR OF ESTI. MATED <i>4:30 PM</i>		2c. DATE PRONOUNCED DEAD <i>Jan. 29, 82</i>		2d. HOUR <i>5:15 PM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb 25, 1897</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>84</i>		7. IF UNDER 1 YR. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>				10. CITY OR TOWN OF DEATH <i>Rockville</i>					
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>5110 Parklawn Terrace - T-2</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tailor (Retired)</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <i>5110 Parklawn Terrace</i>				14. FATHER'S NAME FIRST MIDDLE LAST <i>Nishe Finkelstein</i>					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elke Gurevitch</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>					
16b. SOCIAL SECURITY NO. <i>212-03-3201</i>				17. INFORMANT ADDRESS <i>Samuel Swersky; 5110 Parklawn Terr. Rockville, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Infarction.</i> 4292 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>John G. Ball</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>		MEDICAL EXAMINER		DATE SIGNED <i>Jan. 29, 1982</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN G. BALL, M.D.</i>				ADDRESS <i>7936 Old Georgetown Rd., Bethesda, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1-31-1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hyattsville, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Danzansky-Goldberg Chapels;</i>				ADDRESS <i>1170 Rockville, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>FEB 2 1982</i>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. Martin</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

0500 BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE T. Fling</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01-16-82</b>			
3. SEX <b>male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-16-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD	
10. CITY OR TOWN OF DEATH <b>GATHERSBURG</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SGAH</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>MONTG.</b> 13c. CITY OR TOWN <b>Poolesville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Howard Fling</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Simpson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-26 5091</b>		17. INFORMANT ADDRESS <b>Mrs. Fling Poolesville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>MISO CARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>IMMEDIATE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/16/81</b> P.M. 19 <b>78</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (we) (this hospital) attended the deceased from <b>11/16/81</b> to <b>1/16/82</b> that he (we) lost saw the deceased alive on <b>11/16/81</b> and that in (a) (our) opinion death occurred on the date and hour and from the causes stated above, a (we) (did) (declared) view the body after death.							
22b. SIGNATURE <b>Thos B. Ward</b> DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos B. WARD</b>				22e. ADDRESS <b>6116 Robinwood, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MONACACY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beallsville Montg Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W.C. Hiltner</b> ADDRESS <b>Barnesville Md. 20838</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>		25b. REGISTRAR SIGNATURE <b>James G. ...</b>	

Friday

The family went to the  
cemetery to see the  
grave of the late Mr. J. H. Smith.  
He was a very kind and  
generous man and his death  
was a great loss to the  
family. The funeral was  
held on Monday at 10 o'clock  
at the Methodist Church.  
The burial was in the  
cemetery. The family  
was very sad to see  
him go. He was a  
very good man and  
his death was a great  
loss to the family.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
DONALD H. FORD						1 3 1982			3:38					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
MALE	CAUC	8 19 20	61 YRS.			1 3 1982			3:38					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Rhode Island		UNITED STATES				Montgomery MD								
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
SILVER SPRING				HOLY CROSS HOSPITAL				Shipping & Receiving Printing Co.						
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
R.I.				Providence		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		33 EUSTON AVENUE						
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME										
Horatio H. Ford				Etta Durfee										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
yes				036-18-7669		Joan Ford-wife		-(same as 13e)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
None														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
				P.M. 19										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
John S. Rogers, DME				Dep				Jan 3/1982						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
				1919 Seminary Rd., S.S. Md.										
23a. BURIAL, CREMATION, REMOVAL (SPEC)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Cremation				1-4 -1982		Lee's Crematory		Washington, DC						
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Hines/Rinaldi Funeral Home				11800 N.H. Avenue, Silver Spring, Md.				7 1982		James J. Nathan				



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MALE  
CAGE 1  
UNITED STATES  
SILVER SPRING, MARYLAND  
WASHINGTON

*[Faint, illegible handwritten text and markings, possibly a signature or date, are visible at the bottom of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8202157

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>MABEL E Ford</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>January 31/82</u>		2b. HOUR <u>2050 P.M.</u>
3. SEX <u>Female</u>	4. RACE <u>Caucasian</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>April 2 1904</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Rockville</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Director-Christian</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>
13a. STATE <u>md.</u>	13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Gaithersburg</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <u>301 Russell Avenue</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Alvin A. Edge</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Not Available</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>578-20-7390</u>		17. INFORMANT ADDRESS <u>Mr. James D. Ford, Jr., Son, 116 Marseille Dr., Rockville, MD.</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u>
4340 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u>					<u>3 years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>					<u>3 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Systolic hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1981</u> to <u>Jan 31 1982</u> , that (I) (we) last saw the deceased alive on <u>Jan 31 1982</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>James R. Moore Jr.</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>2-1-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>James R. Moore Jr.</u>		22e. ADDRESS <u>207 Brookes Ave Gaithersburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>Feb. 4, 1982</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery, Brentwood, Maryland</u>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <u>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</u>		25a. DATE REC'D. BY REGISTRAR <u>FEB 8 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>	

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Handwritten text, mostly illegible due to fading and bleed-through. Some words like "Title" and "Subject" are faintly visible.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mamie Johnson Ford</b>			7a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1/27 19 82</b>			7b. HOUR <b>4:20 P.</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jun. 23, 1887</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD <b>1/27 19 82</b>		
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7e. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3529 Cherry Valley Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>H.Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Olney</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3529 Cherry Valley Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>W. E. Johnson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Genettia</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>218-54-5004</b>		17. INFORMANT ADDRESS <b>Gordon B. Ford Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> <b>4291</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>None</b>								
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>1/28/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>JAN. 28, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE CREMATORY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>				ADDRESS <b>LAYTONSVILLE, MD. 20879</b>		25a. DATE FILED BY REGISTRAR <b>FEB 2 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>

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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>William Edward Ford</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 12 82</b>		2b. HOUR <b>10:00</b> P.M.	
3. SEX <b>Male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 29, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Black Bird, Del.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Tacoma Park MONTGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Tacoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md</b>	13b. COUNTY <b>Queen Anne</b>	13c. CITY OR TOWN <b>Grasonville</b>	13e. STREET ADDRESS <b>Grasonville, Md. 21638</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rese Ford</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Weller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>159-09-6828A</b>		17. INFORMANT ADDRESS <b>Ida Pearl Ford Grasonville, Md. 21638</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>1850 Cardiac-Pulm arrest</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Long Heart Failure</b>							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CA Prostate - Metastases</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Upper GI Hemorrhage Contributed Anemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-26</b> , 19 <b>81</b> , to <b>1-12</b> , 19 <b>82</b> , that (II) (we) last saw the deceased alive on <b>1-12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.H. Sandstrom M.D.</b>				DEGREE		22c. DATE SIGNED <b>1-13-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. H. Sandstrom MD</b>				22e. ADDRESS <b>7701 Carroll Ave Tacoma Park, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crompton Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crompton Queen Anne Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Helfenbein-Hubbard Funeral Home</b>				ADDRESS <b>Chester, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>	
				25b. REGISTRAR'S SIGNATURE <b>Frances Jan Thier</b>			

1912

RECEIVED

NOV 11 1912



NOV 11 1912



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202160			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEIF N. FRANDSEN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1/28/82</b>		2b. HOUR <b>1:30 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 11 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>63 N 14</b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. PLACE OF BIRTH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MILITARY</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>MONT.</b> 13c. CITY OR TOWN <b>S.S.</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>211 EAST INDIAN SP.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rasmus XXXX Frandsen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Doris XXXX Johannessen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>YES WW 11</b>				16b. SOCIAL SECURITY NO. <b>556-20-772</b>		17. INFORMANT NAME ADDRESS <b>Edna C. Frandsen wife</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>STREET</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/22/82</b> , 19 <b>82</b> , to <b>1/27</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/27</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Antonio G. Uy</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/28/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. UY</b>				22e. ADDRESS <b>831 Univ. Blvd. E #25 S.S. Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 1, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>			

27



Autumn 1911  
1st 2nd 3rd 4th 5th 6th 7th 8th 9th 10th 11th 12th

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 1 6 1	
1. DECEASED NAME (TYPE OR PRINT) <b>ROBERTA J. FREIDIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 10, 1982</b>		2b. HOUR <b>2:05A<sub>M</sub></b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 30, 1938</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, NIH, Beth. MD</b>				12a. USUAL OCCUPATION: (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6 Blue Valley Court 20904</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Milton Conn</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Honick</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>000-00-0000</b>		17. INFORMANT NAME ADDRESS <b>Alan B. Freidin Same as 13e.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pneumonitis, several abscesses bilaterally, cause undetermined</b> 7100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Systemic lupus erythematosus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Vegetations of aortic valve, hematoma in space of Retzius, on the anterior surface of urinary bladder. Cerebral focal cortical necrosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 24, 1981</b> to <b>January 10, 1982</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <b>January 10, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (not) view the body after death.											
22b. SIGNATURE <i>S. Canette</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>01-11-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. CANETTE</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, MD 20205</b>							
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>Burial</b>		23b. DATE <b>1/12/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Va.</b>					
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				P.O. Box 7428 ADDRESS <b>Sil. Spr., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>					



FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) **CARL PATRICK FRIEND**

2a. DATE OF DEATH MONTH **JAN** DAY **22** YEAR **82** 2b. HOUR **1400p**

3. SEX **MALE** 4. RACE **CAUCASION** 5. DATE OF BIRTH **NOV 29 1911** 6. AGE (IN YEARS LAST BIRTHDAY) **70** 7. IF UNDER 1 YEAR MONTHS **0** DAYS **0** 8. IF UNDER 24 HRS. HOURS **0** MIN. **0**

9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **WEST VIRGINIA** 9b. CITIZEN OF WHAT COUNTRY? **USA** 10. MARRIED ☒ NEVER MARRIED ☐ 11. WIDOWED ☐ DIVORCED ☐ 12. BALTIMORE CITY OR COUNTY OF DEATH **MONTGOMERY** MD.

13a. CITY OR TOWN OF DEATH **BETHESDA** 13b. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **NATIONAL NAVAL MEDICAL CENTER** 14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **RETIRED ASST. GEN. COUNSEL** 14b. KIND OF BUSINESS OR INDUSTRY **GAO**

15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15b. STATE **MD** 15c. COUNTY **MONTGOMERY** 15d. CITY OR TOWN **SILVER SPRING** 15e. INSIDE CITY LIMITS? YES ☒ NO ☐ 15f. STREET ADDRESS **1901 DENNIS AVENUE**

16a. FATHER'S NAME FIRST **EDWARD** MIDDLE **OLIVER** LAST **FRIEND** 16b. MOTHER'S MAIDEN NAME FIRST **GEORGEANNA** LAST **GEORGIANA** 16c. ADDRESS **XXXXXX**

17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **YES** 17b. SOCIAL SECURITY NO. **1951-1971** 17c. INFORMANT **SON** ADDRESS **DENNIS C. FRIEND 1006 FOWLER ST. FALLS CHURCH VA**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **ADENOCARCINOMA OF PROSTATE**  
DUE TO, OR AS A CONSEQUENCE OF (b) **1850**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **1850**

19a. DATE OF OPERATION **17 JAN 82** 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED **17 JAN 82** 19c. AUTOPSY? YES ☒ NO ☐ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **19 19** 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) **19 82**

21a. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) **19 82** 21c. LOCATION STREET CITY OR TOWN COUNTY STATE **19 82**

22a. I certify that I (this hospital) attended the deceased from **17 JAN 82** to **22 JAN 19 82**, that I (we) last saw the deceased **22 JAN 19 82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.

22b. SIGNATURE **Gary Zaloga** DEGREE **MD** 22c. DATE SIGNED **23 Jan 82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **DR. GARY ZALOGA** 22e. ADDRESS **WISCONSIN AVENUE BETHESDA MD.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **BURIAL** 23b. DATE **1/26/82** 23c. NAME OF CEMETERY OR CREMATORY **ARLINGTON NATIONAL** 23d. LOCATION **ARLINGTON** COUNTY **VA**

24. FUNERAL DIRECTOR NAME **COLLINS FUNERAL HOME** ADDRESS **UNIVERSITY BLVD** 25a. DATE REC'D. BY REGISTRAR **JAN 27 1982** 25b. REGISTRAR'S SIGNATURE **Francis J. Northen**

MEDICAL CERTIFICATION

(14)

CONFIDENTIAL

CONFIDENTIAL

(14)

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL



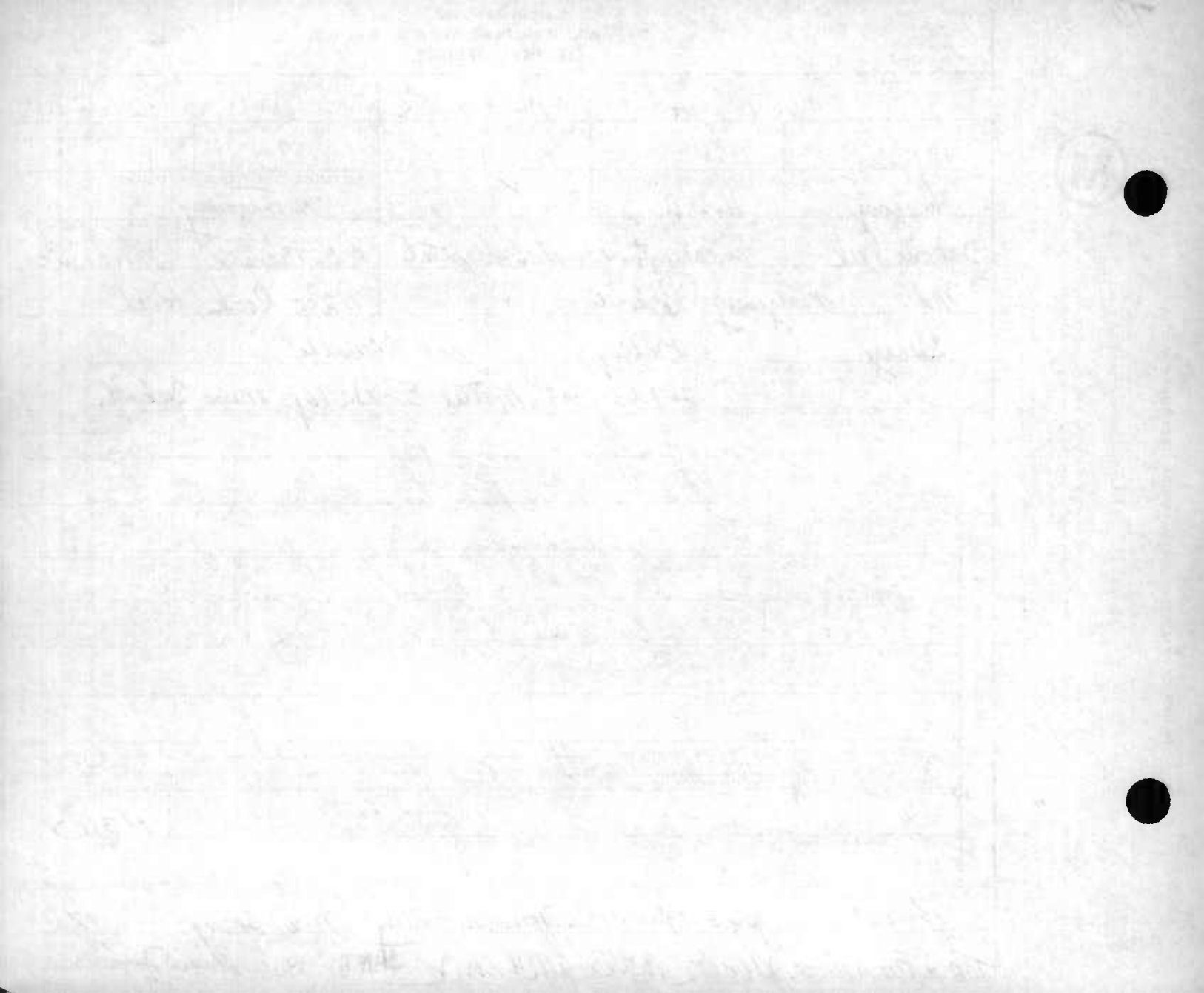
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 6 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMORY A GALLEY, SR				2a. DATE OF DEATH MONTH DAY YEAR 1 3 82			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5 9 06		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Jakovs Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) S. C. Tramot		12b. KIND OF BUSINESS OR INDUSTRY Mechanic	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.				13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Galley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Not Available		16. STREET ADDRESS 11200 Rock Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 267-03-9303		17. INFORMANT ADDRESS Matthew E. Galley, 11200 Rock Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4920 Pulmonary Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Emphysema				APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH Yes			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Arteriosclerotic Heart Disease							
19a. DATE OF OPERATION 7/33/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rt Colon Hemorrhage		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN PART 1 OR PART 2)			
22a. INJURY OCCURRED 22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		22c. LOCATION (STREET CITY OR TOWN COUNTY STATE)		22d. I certify that (b) (this hospital) attended the deceased from 7/10/81 to 1/3/82 that (b) (we) last saw the deceased alive on 1/3/82 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) see the body after death.			
22e. SIGNATURE H. L. Martel		22f. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. MARTEL		22g. ADDRESS 831 University Blvd E Silver Spring Md.		22h. DATE SIGNED 11/3/82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 6, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION (CITY OR TOWN COUNTY STATE) Silver Spring Md.	
24. FUNERAL DIRECTOR NAME Jakovs Funeral Home, J. J. J. J.				25a. DATE REC'D. BY REGISTRAR JAN 6 1982			
25b. REGISTRAR'S SIGNATURE Thome J. J. J.				25c. REGISTRAR'S NAME Thome J. J. J.			





1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 6 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NELDA G. GARTNER			2a. DATE OF DEATH MONTH DAY YEAR 1/19/1982		2b. HOUR 10:30 AM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 1 28 1920		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adv Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 401 Dogwood Drive	
14. FATHER'S NAME FIRST MIDDLE LAST William E. GWYN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELVA MAY SAKERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 13-16-2865		17. INFORMANT ADDRESS George M. Gartner 401 Dogwood Dr. Gaith. Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac Arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u> Approximate interval between onset and death: <u>10 days</u>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Coronary

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Michael A. Bolognese, M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/19/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Bolognese, M.D.		22e. ADDRESS 19261 Montgomery Village Ave., Gaith. Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/22/'82	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montg. Md.
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24. FUNERAL DIRECTOR Gartner Sandison F. H. Gaithersburg, Md. 20877	25a. DATE REC'D. BY REGISTRAR JAN ~ 1 1982	25b. REGISTRAR'S SIGNATURE [Signature]
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 6 5

1 - FOR STATE REGISTRAR		2 - AKA Joan Gauthier GAUTHIER		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE ANNE		3. SEX FEMALE		4. RACE CAUC	
5. DATE OF BIRTH MONTH DAY YEAR MARCH 18, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 62		7. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1982	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		9. CITIZEN OF WHAT COUNTRY? USA		10. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
11. CITY OR TOWN OF DEATH BETHESDA		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Assembler	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA 13b. COUNTY FAIRFAX 13c. CITY OR TOWN FALLS CHURCH		15. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX		16. STREET ADDRESS 2215 PIMMIT DRIVE FALLS CHURCH, VA 22042	
17. FATHER'S NAME FIRST MIDDLE LAST FRANK MOGELNICKI		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA BUJER		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
20. SOCIAL SECURITY NO. 020-22-5876		21. INFORMANT REXINA E. PETITT: LINDEN, VA 22642		22. ADDRESS P.O. BOX 106	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST		24. DUE TO, OR AS A CONSEQUENCE OF (b) LARGE CELL CARCINOMA WITH INVASION OF LUNG		25. DUE TO, OR AS A CONSEQUENCE OF (c)	
26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1991		27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED	
29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		30. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
32. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		33. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE	
35. I certify that (I) (this hospital) attended the deceased from 04 JANUARY 19 82 to 04 JANUARY 19 82, that (I) (we) last saw the deceased alive on 04 JANUARY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		36. SIGNATURE H. L. REED LT MC USNR		37. DATE SIGNED 5 Jan 82	
38. PHYSICIAN'S NAME (TYPE OR PRINT) H. L. REED, LT, MC, USNR		39. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.		40. DATE REC'D. BY REGISTRAR JAN 8 1982	
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		42. DATE 1/7/82		43. NAME OF CEMETERY OR CREMATORY Arl. National Cemetery	
44. FUNERAL DIRECTOR Murphy Funeral Home		45. ADDRESS Falls Church, Virginia		46. DATE REC'D. BY REGISTRAR JAN 8 1982	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) THOMAS W. GAVETT					2a. DATE OF DEATH MONTH DAY YEAR 1-14-82			2b. HOUR 7:45 PM	
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan 16 1932		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bethesda Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Economist-Bur. of Labor		12b. KIND OF BUSINESS OR INDUSTRY Statistician	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5101 River Rd #602	
14. FATHER'S NAME FIRST MIDDLE LAST Harold S. Gavett					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verona Reinhold				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Bethesda, MD 20816 Patricia D. Gavett-wife 5101 River Rd. #602					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 3320 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JAN. 1967</u> , to <u>1-14-82</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>1-14-82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>the (we) did not</del> view the body after death.									
22b. SIGNATURE <u>Thomas Berg</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1-14-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Jan. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002		
24. FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002					25a. DATE REC'D. BY REGISTRAR JAN 20 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas Berg</u>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

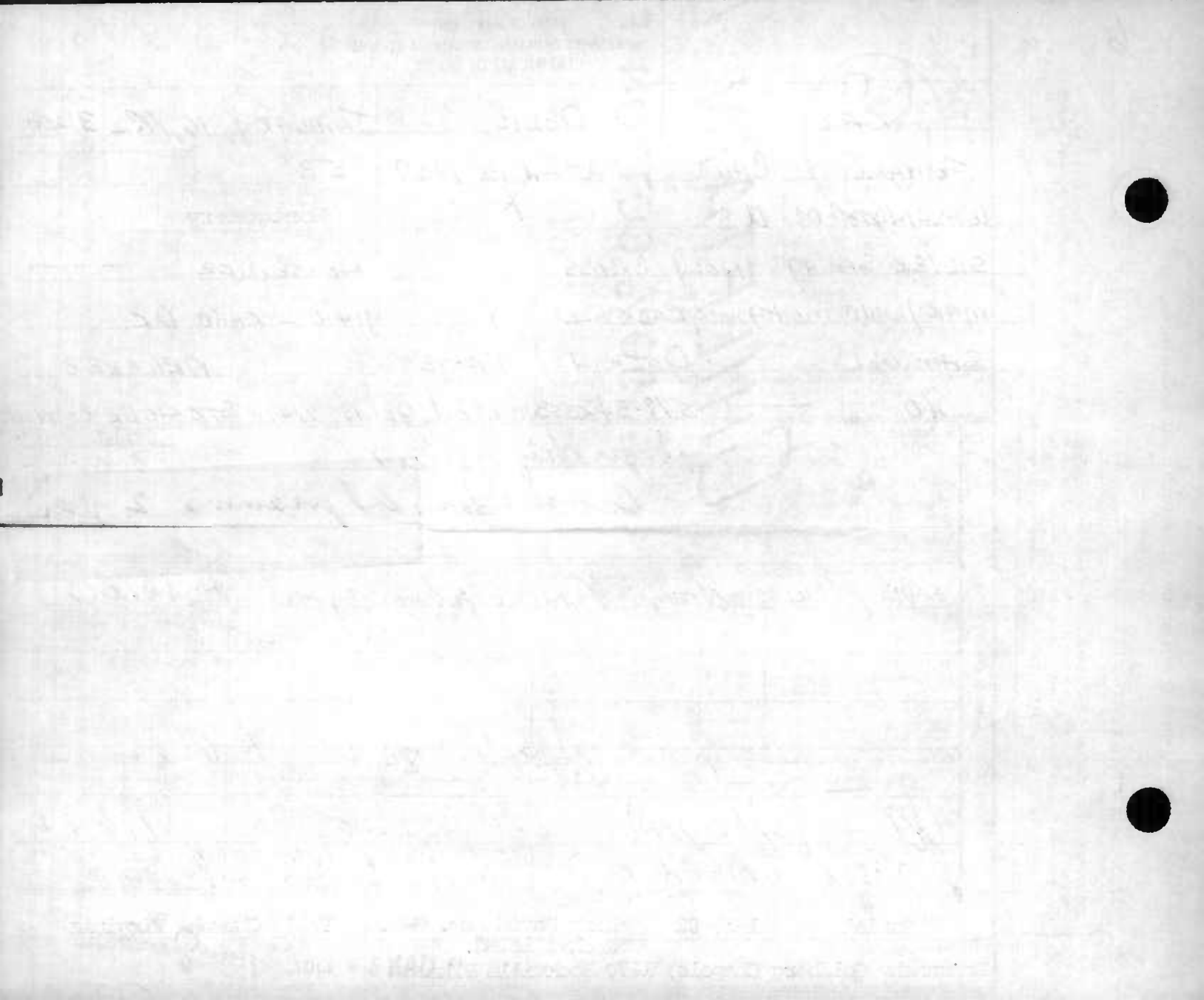
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 6 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RAE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 16 1982</b>			2b. HOUR <b>2:20 AM</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 12, 1929</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>53</b>		7. UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>ROCKVILLE</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL GOTKIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATIE DEUCKER</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>578-34-0553</b>			17. INFORMANT <b>MILTON GELB</b> ADDRESS <b>11410 STRAND DR. ROCKVILLE</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4940</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b> Approximate interval between onset and death: <b>3 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>Left pneumonia; Gram negative sepsis; GI bleeding</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) <b>this hospital</b> attended the deceased from <b>September 1, 1980</b> to <b>1-16, 1982</b> , that (1) <b>was</b> lost saw the deceased alive on <b>1-15, 1982</b> , and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (1) <b>was</b> <b>not</b> view the body after death.										
22b. SIGNATURE <b>Jason Geiger M.D.</b>			DEGREE			22c. DATE SIGNED <b>1-16-82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JASON GEIGER, M.D.</b>			22e. ADDRESS <b>8030 ANTERON ST. SILVER SPRING, MD. 20910</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-17-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Gdn. Rockville, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels</b>			24b. ADDRESS <b>1170 Rockville Pike</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>				



**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

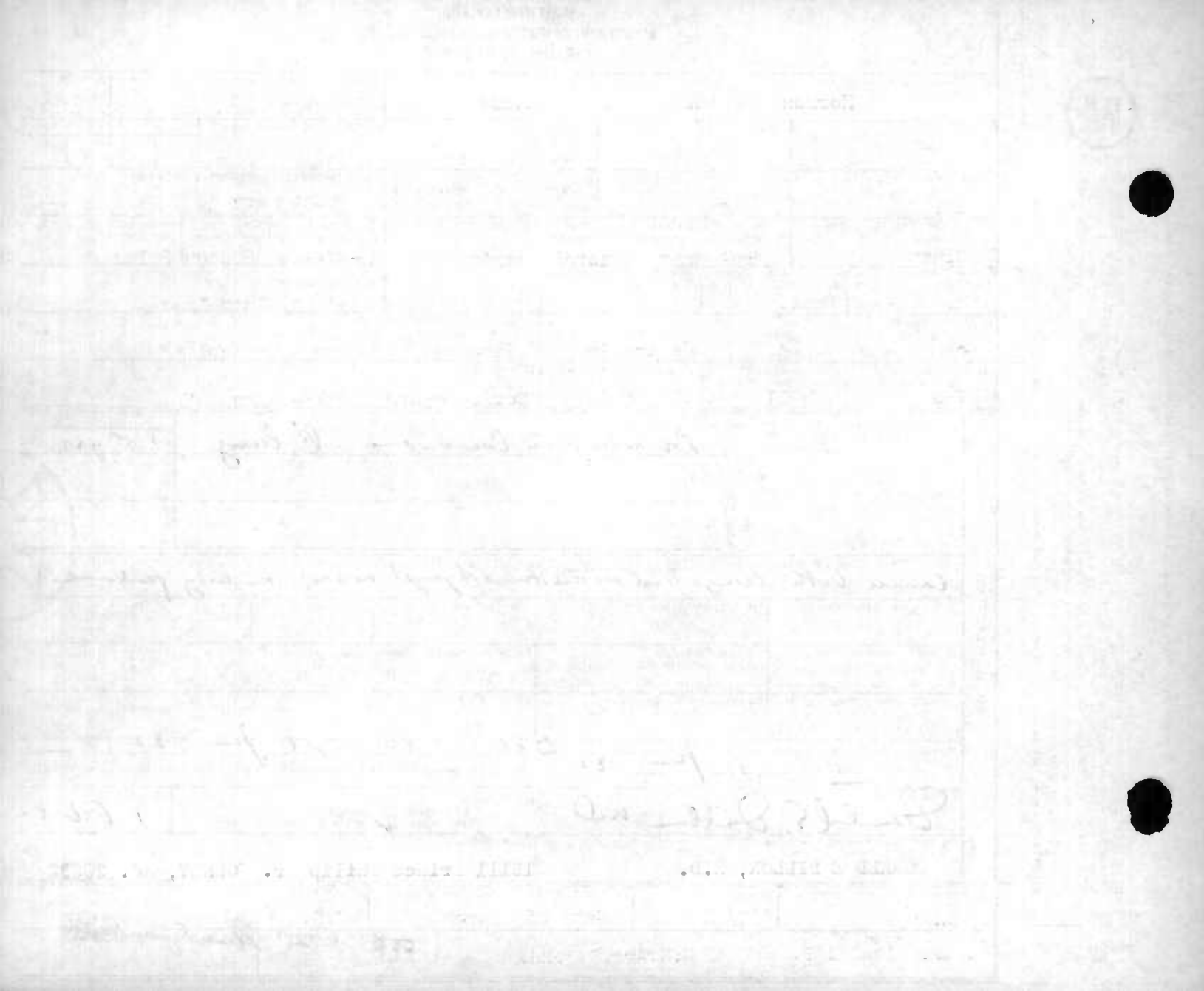
**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8 2 0 2 1 6 8

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH YEAR		2b. HOUR	
Norman A GENARO				January 31, 1982		6:10p		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male		White		May 9 1926		55 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
D.C.		USA				Montgomery MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital				Draftsman Syscon		Sales	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
		Md.		Mont.		Olney		4400 Mt. Olney Lane	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Norman A Genaro, Sr.				Jeanette Mary Marucci					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES WWII				579 24 6045		Doris Genaro(Wife) Same as 13E			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma R lung</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1.5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>Cancer both lungs and mediastinal lymph nodes; Kidney failure</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 31</u> 19 <u>80</u> , to <u>Jan 31</u> 19 <u>82</u> , that (I) <del>was</del> lost saw the deceased alive on <u>31 Jan 19 82</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did not) view the body after death.									
22b. SIGNATURE <u>Donald E. Dillon M.D.</u> DEGREE						22c. DATE SIGNED <u>1 Feb 82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E DILLON, M.D.						22e. ADDRESS 18111 Prince Philip Dr. OLNEY, Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		2/3/82		Gate of Heaven		S.S. Mont. Maryland			
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.						25a. DATE REC'D BY REGISTRAR <u>FEB 4 1982</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

DHMH-16 30M 2/80  
(VRA 15, 4)

750 DATE REC'D. BY REGISTRAR 250 REGISTRAR SIGNATURE  
FEB 4 1982 [Signature]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 1 6 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1-4-82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eleanor Patricia Gladd				2b. HOUR 1:pm M			
3. SEX FEMALE		4. RACE CAUCASTIAN		5. DATE OF BIRTH MONTH DAY YEAR 3-20-54		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RECEPTIONIST		12b. KIND OF BUSINESS OR INDUSTRY DRS OFFICE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN ZAKOSKY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE KALINOWSKI		13e. STREET ADDRESS 14717 MYER TERRACE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 149-20-1774		17. INFORMANT ADDRESS WALTER FRANK GLADD SAME AS 13 HUSBAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Central Nervous System Metastases							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Large cell carcinoma of Lung							4 months
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (as hospital) attended the deceased from 1/14/82 to 1/31/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE G. Lennard Gold, MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LENNARD GOLD				22e. ADDRESS SILVER SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/7/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 8 1982		25b. REGISTRAR'S SIGNATURE	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



Classified by 2000

1. The purpose of this document is to provide information regarding the classification of documents and the procedures for declassification. This document is classified "CONFIDENTIAL" and is to be controlled in accordance with the provisions of Executive Order 11652, dated August 3, 1966, and the provisions of the Federal Acquisition Regulation (FAR) regarding the classification of documents.

2. The classification of documents is based on the information contained in the document and the potential for damage to the national defense if the information is disclosed to unauthorized persons. Documents are classified "CONFIDENTIAL" if they contain information that is so classified by the originating agency and is not otherwise available to the public.

3. The procedures for declassification of documents are set forth in the Federal Acquisition Regulation (FAR) and the provisions of Executive Order 11652, dated August 3, 1966. Documents are declassified when the information contained in the document is no longer considered to be of value to the national defense.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

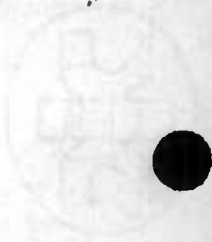
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 1 7 0	
1 - STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Billye JEAN WINTER Glassman</u>						2a. DATE OF DEATH MONTH <u>1</u> DAY <u>22</u> YEAR <u>82</u>		2b. HOUR <u>12.40</u> P			
3. SEX <u>FEMALE</u>		4. RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH <u>3</u> DAY <u>04</u> YEAR <u>25</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>56</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>	
7a. BIRTHPLACE (STATE OR FOREIGN) <u>KANSAS</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County, MD</u>					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>G.A.</u>		13c. CITY OR TOWN <u>CHESTER</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>ROUTE 1, BOX 367</u>			
14. FATHER'S NAME FIRST <u>ALFRED</u> MIDDLE <u>A.</u> LAST <u>WINTER</u>				15. MOTHER'S MAIDEN NAME FIRST <u>GERTRUDE</u> MIDDLE <u>A.</u> LAST <u>HOUGH</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <u>515-14-1640</u>		17. INFORMANT <u>DAUGHTER</u> <u>TRUDY J. BRYLAWSKI</u>		ADDRESS <u>5513 NORBECK ROAD</u> <u>ROCKVILLE, MD. 20853</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> <u>5715</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Encephalitis of liver.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Diabetic mellitus</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 5, 1980</u> to <u>Jan 22, 1982</u> , that (I) <u>may</u> lost saw the deceased alive on <u>Jan 22, 1982</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If I <u>did</u> <u>did not</u> view the body after death.											
22b. SIGNATURE <u>Morton Altschuler MD</u>				DEGREE				22c. DATE SIGNED <u>Jan 22, 1982</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Morton Altschuler MD</u>				22e. ADDRESS <u>1299 - Cambridge Dr</u> <u>Silver Spring, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>1/26/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>ARLINGTON VIRGINIA</u>					
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u> <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 27 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202171			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) Theodore B. Godfrey				2b. HOUR 3:37 M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician - Bureau of Standards		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer E. Godfrey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Arenot		13e. STREET ADDRESS 7508 Old Chester Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-44-8403		17. INFORMANT ADDRESS Md. Jamie E Godfrey 2559 Steele Rd. Baltimore, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIAC + RESPIRATORY ARREST 1 1/2 HOURS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 HOURS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADVANCED CONGESTIVE FAILURE 6 MONTHS				(c) ARTERIOSCLEROTIC C-V DISEASE			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 19 1978 to JAN 15 1982 that (I) (we) last saw the deceased alive on JAN 15 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dr. Ball released body taken by Edward W. Youngblood, M.D.				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Jan. 15, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD W. YOUNGBLOOD				22e. ADDRESS 4900 MASS. AVE. N.W. WASHINGTON, D.C. 20016			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/18/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wis. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	

JAN 21 1982

James W. Youngblood



Mr. J. Edgar Hoover  
U.S. Department of Justice  
Washington, D.C. 20535

Very truly yours,  
[Signature]  
Special Agent in Charge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 1 7 2	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lena Goldberg</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 24, 1982</b>			2b. HOUR <b>7:45P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>91 YRS</b>		7. IF UNDER 1 YEAR IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LATVIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Wash.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Sil. Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1401 Blair Mill</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Effenbach</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Schiffra Michaelson</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>577-50-4784A</b>		17. INFORMANT ADDRESS <b>Washington, D.C.</b>						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrhythmias</b> <b>0389</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Possible myocardial infarction</b> (c) <b>Septicemia (Pneumonia)</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>NO</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>1/24/82</b> to <b>1/24/82</b> , that (I) (we) last saw the deceased alive on <b>1/24/82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>H.D. Khianey</b>					DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/26/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HIRSH D. KHIANEY</b>					22e. ADDRESS <b>6121 Montrose Rd, Rockville, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (IF BURIAL) <b>Burial</b>			23b. DATE <b>1/26/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cem. of Adas Israel Cong. Washington, D.C.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR'S NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>					25a. DATE REC'D BY REGISTRAR 155 REGISTRAR'S SIGNATURE <b>JAN 27 1982 Charles J. Smith</b>						



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Anna NMN Goldman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 5, 1982</b>		2b. HOUR <b>9:40 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>December 31, 1982</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Rockville-Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Wash.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Grocery Owner</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Menachim M. Stoller</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Mudrick</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-84-0963</b>		17. INFORMANT ADDRESS <b>Bethesda, Maryland</b> <b>Dorothy Zendel-7420 Westlake Terrace, Apt. 701</b>	

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

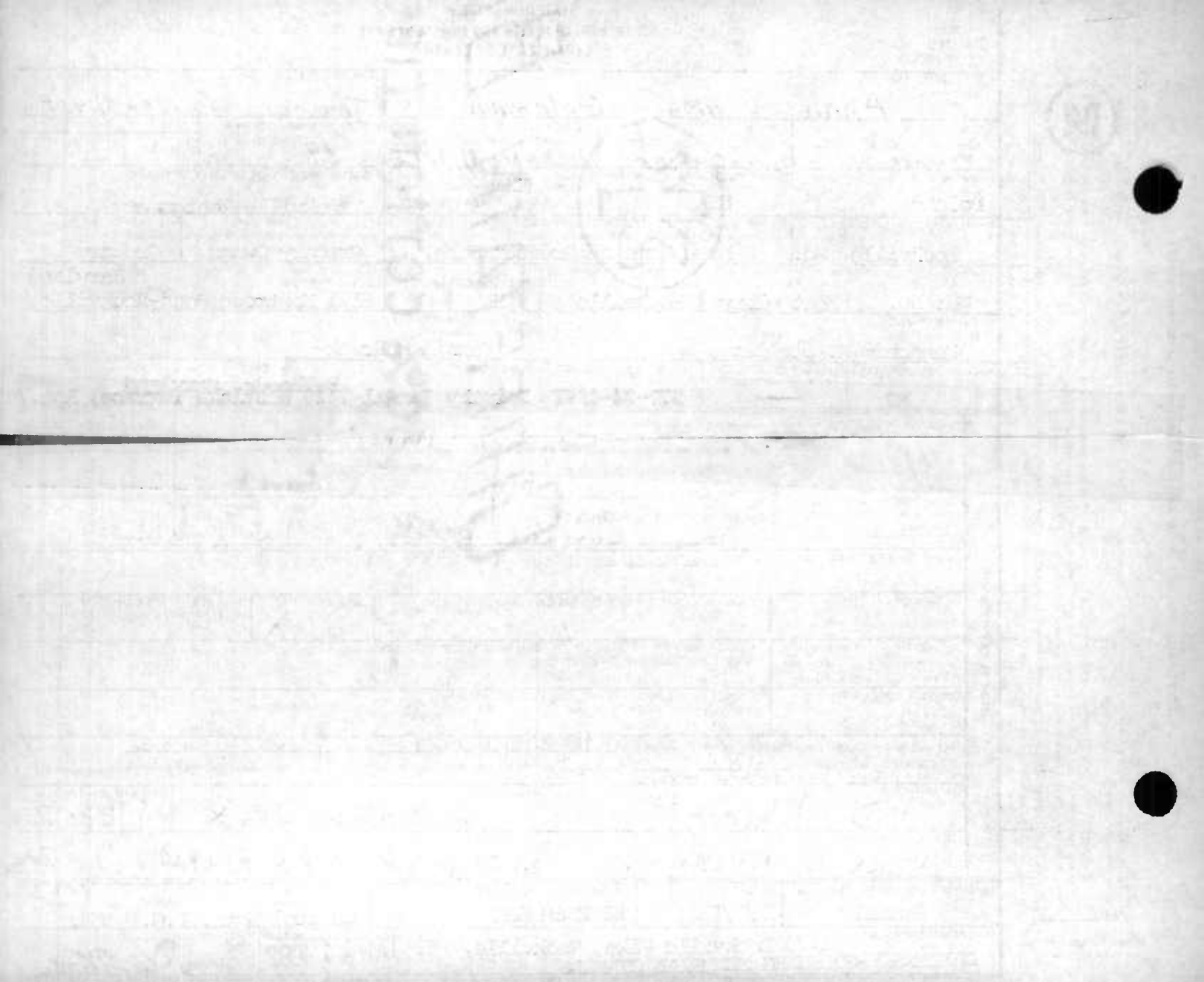
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/2/77</b> 19 <b>77</b> , to <b>1/5/82</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/5/82</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>H.D. Khianey</b>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>1/6/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HIRSH D. KHIANEY</b>	22e. ADDRESS <b>6121 Montrose Rd, Rockville, Md. 20852</b>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1/7/82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Capitol Hgts., P.G. - Md.</b>
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				8202174			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna Augusta Grant</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1 14 82</i>		2b. HOUR <i>5:25 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7 7 1899</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Herman Wilson Health Care Center</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Md.</i>				13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Mt. Airy</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Augustus Riggs Bidinger</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary H. Ritter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>?</i>		17. INFORMANT ADDRESS <i>Alameda Moxley Mt. Airy, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal carcinoma sigmoid colon July 1981</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1981</i> 19____, to <i>Jan 1982</i> 19____, that (I) (we) last saw the deceased alive on <i>Dec 1981</i> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i> MD		DEGREE		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/15/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D'SOOTH LEKAGUL, MD</i>		22e. ADDRESS <i>7415 arlington Rd. Beltsville Md</i>					
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>		23b. DATE <i>1-17-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. View Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Montgomery County Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Harry W. Haight Sykesville, Md.</i>		25a. DATE REG'D. BY REGISTRAR <i>JAN 18 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2 0 2 1 7 5	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST	
Viola		Green	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY)
Female	Black	Feb. 28, 1945	36 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
NC	USA		Montgomery County, MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Rockville	511 Pinwood Road	unemployed	-----
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
Md	Montgomery	Rockville	511 Pinwood Rd
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST	17. INFORMANT ADDRESS	
Vincent E. White	Margaret Sesson	(husband) Oxon Hill Md. Matthew Green 1125 Marcy Ave.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
no	228-60-9685		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of mouth (Handgun)</u> 9550 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 1 19 82	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		subject shot herself	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		511 Pinwood Road, Rockville, Montgomery Co., Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED	
Virginia L. Dolan, M.D.		1-20-82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
burial		1-23-82	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Harmony Memorial		Landover Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR	
FRAZIER'S 389 Rhode Island Ave. NW		JAN 25 1982	

RECEIVED  
JUN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
AFMPC  
WRIGHT-PATTERSON AFB  
OHIO 45433

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DHMH - 16 50M 1/81  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 1 7 6			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
			DONALD NMN GREENBERG				January 3, 1982				3:00A M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			White		March 23, 1931		50 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
New York			U.S.A.					Montgomery MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Clinical Center, NIH, Beth. MD						Statitian		U.S. Gov't.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland			P.G. Co.		Lanham		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7013 Woodside Dr., 20801				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
FIRST MIDDLE LAST			FIRST MIDDLE LAST										
Harry - Greenberg			Mary - Kopkin										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No			None		131-22-4258		Mrs. Marjorie Greenberg (Wife) = Same						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse pneumonitis, bilateral lower lung lobes</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Enlarged lymph nodes, generalized (H/O Chronic lymphocytic leukemia)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
			HOUR A.M. MONTH DAY YEAR										
			P.M. 19										
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION								
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					STREET CITY OR TOWN COUNTY STATE								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 2, 19 81</u> , to <u>January 3, 19 82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 3, 19 82</u> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <u>xxx</u> (we) (did not) view the body after death.													
22b. SIGNATURE						DEGREE		22c. DATE SIGNED					
<u>Christine D. Berg, M.D.</u>								1-3-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
CHRISTINE D. BERG, M.D.						National Institutes of Health, Clinical Center, Bethesda, MD 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION						
Cremation			Jan/5/82		Cedar Hill Crematory		CITY OR TOWN COUNTY STATE						
							Suitland, P.G. Co., Maryland						
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
NAME ADDRESS						JAN 11 1982		<u>Frances Jan Nathan</u>					
Chambers Funeral Home Riverdale, Maryland													

MEDICAL CERTIFICATION



NEW YORK

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THE NEW YORK PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
500 N. 5TH ST. NEW YORK, N. Y.

1901  
THE NEW YORK PUBLIC LIBRARY  
ASTOR LENOX TILDEN FOUNDATION  
500 N. 5TH ST. NEW YORK, N. Y.

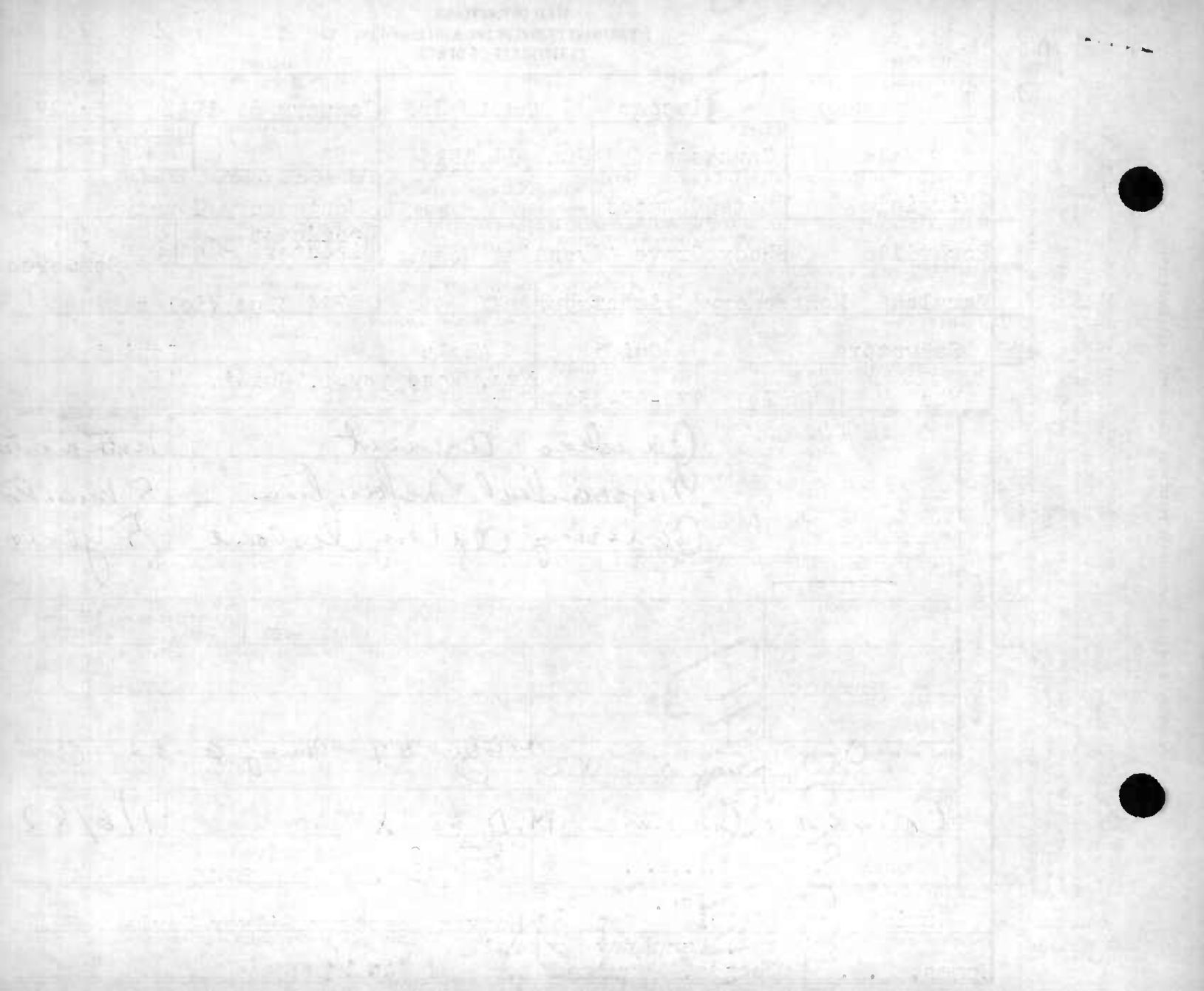
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Hugh Vincent Guidi, Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 6, 1982</b>			2b. HOUR <b>3:02P M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b>				12a. USUAL OCCUPATION (GIVE FULL WORKING LIFE) <b>Director - Chamber of Commerce</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>18744 Blue Violet Lane</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Salvatore Guidi</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adele Papini</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>					16b. SOCIAL SECURITY NO. <b>223-05-4595</b>		17. INFORMANT NAME AND ADDRESS <b>Mrs. Rosemary T. Guidi, Wife, Same as item #9</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Under minute</b> <b>5 minutes</b> <b>3 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (i) (this hospital) attended the deceased from <b>October 5, 1981</b> to <b>January 6, 1982</b> , that (ii) (we) last saw the deceased alive on <b>January 5, 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (ii) (we) (did) (did not) <b>touch</b> the body after death.									
22b. SIGNATURE <b>Donald Q. Ekman</b> DEGREE <b>M.D.</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald Q. Ekman M.D., P.A.</b>					22e. ADDRESS <b>4720 Chevy Chase Drive Chevy Chase, Maryland 20815</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery, Silver Spring, MD.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

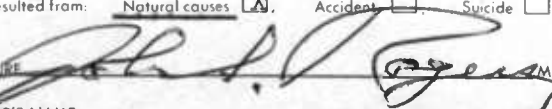

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

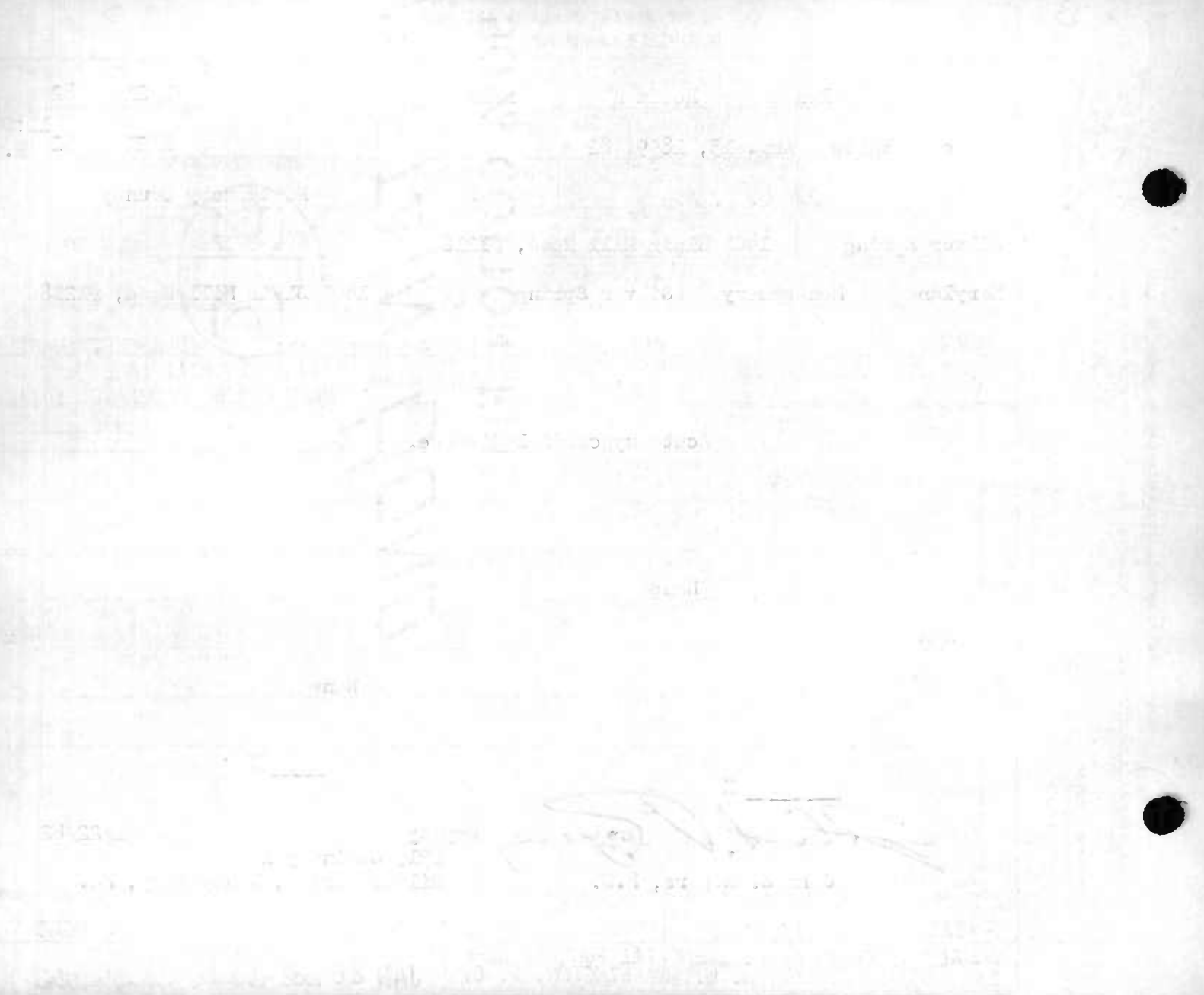
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 7 8			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Paul GWENNAP</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 12, 1982</b>		2b. HOUR <b>1245 PM</b>	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 12, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Buyer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>West Virginia</b> 13b. COUNTY <b>Ohio</b>		13c. CITY OR TOWN <b>Wheeling</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1290 National Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Gwennap</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane (Unavailable)</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES <b>No</b>			
16b. SOCIAL SECURITY NO. <b>174-05-9225</b>		17. INFORMANT ADDRESS <b>Audrey M. Gwennap, 19336 Transhire Road Gaithersburg, MD 20879</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5609 Cardio-Respiratory Arrest.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Epox-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Perforation</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>Dysrhythmia - Renal failure - Respiratory failure</b>							
19a. DATE OF OPERATION <b>1-6-82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>1-6-82</b> 19 <b>82</b> to <b>1-12</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-11-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) see the body after death.							
22a. SIGNATURE <b>Gustavo Restrepo</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-12-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gustavo Restrepo</b>		22e. ADDRESS <b>6215 Greenbelt Rd College Pk Md 20740</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>January 16, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkview Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wheeling, West Virginia</b>	
24. FUNERAL DIRECTOR Ives Funeral Home NAME ADDRESS <b>2847 Wilson Blvd., Arlington, VA 22201</b>				25a. DATE OF DEATH BY REGISTRAR <b>JAN 18 1982</b> 25b. REGISTRAR'S SIGNATURE			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 1 7 9	
1- FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Helen Hahn</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1/21 19 82	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 13, 1899</b>		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. <b>82 YRS.</b>		IF UNDER 1 YR. IF UNDER 24 HRS.		2b. DATE OF ESTI- MATED DEATH <input type="checkbox"/> MONTH DAY YEAR 1/21 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>AUSTRIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1401 Blair Mill Road, #1218</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1401 Blair Mill Road, #1218</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>MEDEL HOFFMAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(UNASCERTAINABLE) (UNASCERTAINABLE)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>JACK HAHN, 9014 SPRINGHILL LANE, CHEVY CHASE, MARYLAND 20815</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a. <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER				DATE SIGNED <b>1/22/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road, Silver Spring, Montgomery, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/24/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>UNITED HEBREW CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>STATEN ISLAND NEW YORK</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 1 8 0			
1- FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) <b>Leathanna B Hale</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-12-82</b>				2b. HOURS <b>5 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 2 17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9321 Warren ST</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>David J. Bready</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Oliver Leathanna Hardy</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>550-44-7937</b>		17. INFORMANT ADDRESS <b>Robert Hale Silver Spring, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CANCER OF LUNG METASTASIS 4 MONTHS</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>90</b>		CITY OR TOWN <b>11/12</b>		COUNTY <b>82</b>		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>82</b> , 19 <b>90</b> , to <b>11/12</b> , 19 <b>82</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>11/12</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>David Goldenberg MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/12/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID GOLDENBERG MD</b>						22e. ADDRESS <b>9801 CRENSHAW</b>		CITY OR TOWN <b>SILVER SPRING, MD</b>		STATE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery Forest Glen, Maryland</b>		23d. LOCATION CITY OR TOWN COUNTY STATE							
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		P.O. Box 7428 <b>Sil. Spr., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>									





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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RICHARD LOUIS HAMEL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 10, 1982</b>		2b. HOUR <b>8:02 am</b>		
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 26, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>57</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KANSAS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>ANNANDALE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS ARTHUR HAMEL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY LOUISE THYFAULT</b>		13e. STREET ADDRESS <b>4422 CARRICO DRIVE ANNANDALE, VIRGINIA 22003</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1943-1963</b>		17. INFORMANT <b>PAULETTE HAMEL</b>		17. ADDRESS <b>4422 CARRICO DRIVE ANNANDALE, VIRGINIA 22003</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC MELANOMA</b> 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <b>09 JANUARY 19 82</b> to <b>10 JANUARY 19 82</b> , that (I) (we) lost saw the deceased alive on <b>10 JANUARY 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>G. Sladek</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>11/1/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. SLADEK, LCDR, USNR, MC</b>		22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 13 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Wayne F. F. F.</b> <b>Demaine Funeral Homes, Inc., Alex., Va. 22314</b>		25. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25. REGISTRAR'S SIGNATURE <b>Amel</b>					

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.



RECEIVED - 1914



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 8 2

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH Marguerite HANAGAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 27, 1982</b>		2b. HOUR <b>3:45 M</b>
3. SEX <b>female</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Mar. 4 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>G.S.A.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>13210 Twinbrook Parkway # 204</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Hanagan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Sheehan</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>578-01-6946</b>		17. INFORMANT <b>Sister Marguerite G. Parker</b>		ADDRESS <b>4912 7th St. N.W. Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Aspiration</b> (c) <b>Malnutrition</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>2 months</b> <b>2 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>2639</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 80</b> to <b>Jan 26 19 82</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>Jan 26 19 82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>Patricia D Kellogg MD</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/28/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICIA D. KELLOGG</b>		22e. ADDRESS <b>809 Veirs Mill Road Rockville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Feb. 1, 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>	25b. REGISTRAR'S SIGNATURE <b>Thomson</b>

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 8 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BENJAMIN F. MARTLEY</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>1 16 82 1:25 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 16 '09</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wilson Health Care Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret'd Minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>W.Va.</b> 13b. CITY OR TOWN <b>Berkley</b> 13c. CITY OR TOWN <b>Martinsburg</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>306 So. Maple Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James David Hartley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mittie Jane Burner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-05-6949</b>		17. INFORMANT ADDRESS <b>301 Russell Ave., Health Care Center Records/Gaithersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERALIZED METASTATIC</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE PROSTATE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV. 5</b> , 19 <b>81</b> , to <b>JAN. 16</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>JAN. 14</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.C. Daddario M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.C. DADDARIO M.D.</b>				22e. ADDRESS <b>5413 CEDAR LANE BETHESDA.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/19/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Martinsburg Berkley W.Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Rosedale Funeral Home</b>				25a. JAN 28 1982 RECORDED BY REGISTRAR		25b. SIGNATURE	

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 1 8 4			
1. FOR STATE REGISTRAR				1. DECEASED NAME			
James OLAND Harvey				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR JAN. 14, 82 8:35 PM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 19, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Car N. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief of Div.		12b. KIND OF BUSINESS OR INDUSTRY Mont.Co. Trans	
13a. STATE MARYLAND 13b. COUNTY MONT. 13c. CITY OR TOWN OLNEY				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18201 Hillcrest Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Hiram W. Harvey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie - Oland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 283-18-0428		17. INFORMANT ADDRESS R.B. Sellman Olney, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4960 COPE (chronic obstructive pulm. emphysema) 2 yrs. DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ABEVD with coronary insufficiency							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 80 to Jan. 14, 19 82, that (I) ( ) last saw the deceased alive on Jan. 14, 19 82, and that in (my) ( ) opinion death occurred on the date and hour and from the causes stated above. (I) ( ) (did not) view the body after death.							
22b. SIGNATURE Frederick Moomau MD DEGREE				22c. DATE SIGNED 1-14-82		22d. ADDRESS Prince Philip Dr. Olney, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION Olney Mont. County Md. STATE	
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR JAN 10 1982		25b. REGISTRAR'S SIGNATURE	



1858-1859

Harvey

James



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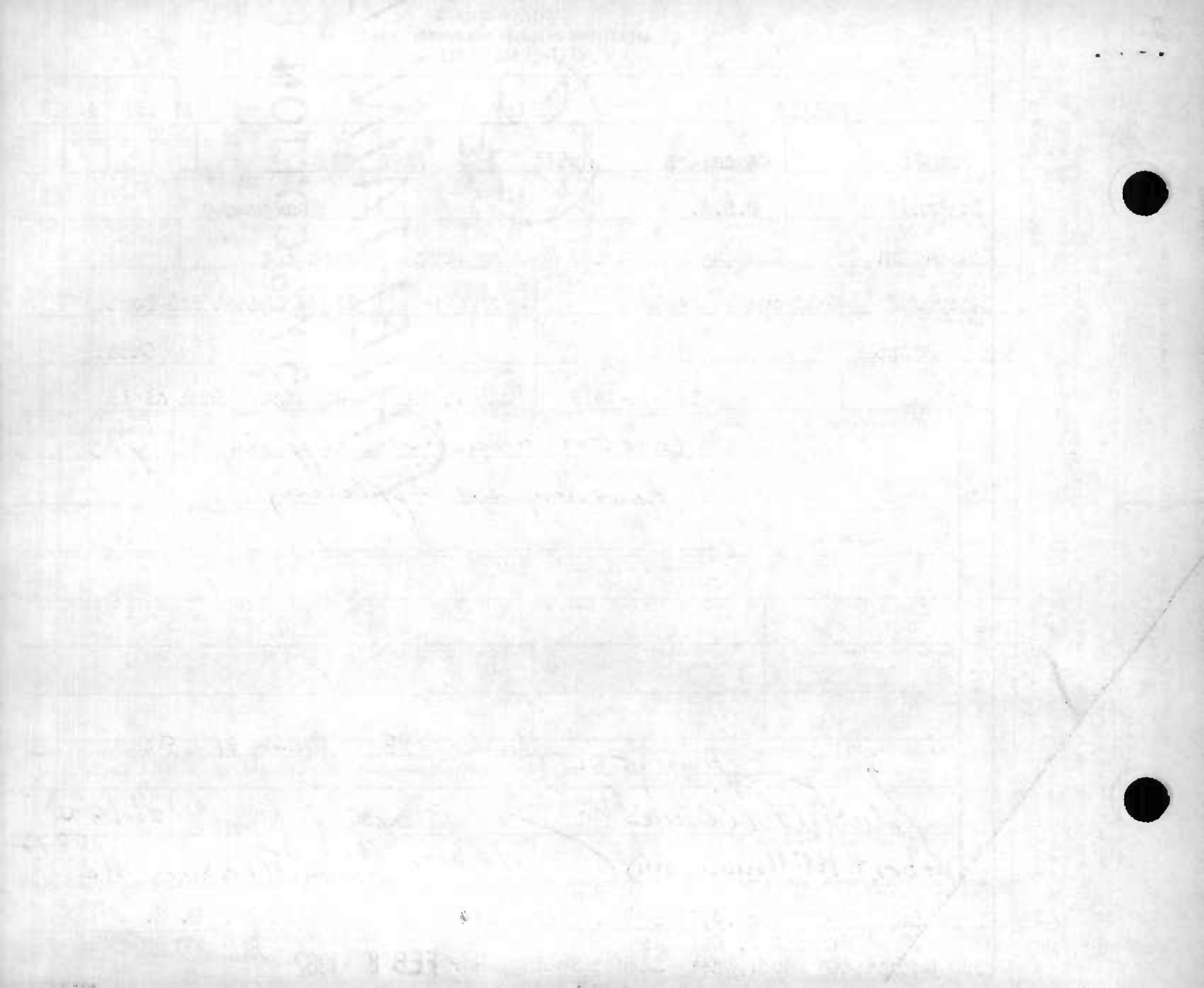
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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 2 0 2 1 8 5							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
NELLIE						HEALEY		MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		Caucasian		April 2 1892		89		6:02P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Ireland		U.S.A.				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington		Kensington Gardens Nursing Home				Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Ashton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		17528 Shenandoah Court	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
Patrick		McHugh		Marie		Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		228-72-1415		Mary F. Kemp Daughter		Same as 13			
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4379		DUE TO, OR AS A CONSEQUENCE OF						YRS	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Coronary insufficiency</u>							
		DUE TO, OR AS A CONSEQUENCE OF							
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>September 19 78</u> to <u>January 31 82</u> , that (I) (we) <u>saw</u> the deceased alive on <u>August 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED	
<u>Robert Millman, MD</u>								2/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Robert Millman, MD		157E Deer Park Dr Gaithersburg Md 20877							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Feb. 4, 1982		Mt. Olivet Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE			
Francis J. Collins		FEB 8 1982				<u>Francis J. Collins</u>			
500 University Blvd., West Silver Spring, Md.									



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FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mildred Lindsay Heatherly</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 3 1982</b>		2b. HOUR <b>11:30P</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 12, 1907</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8201 16th Street, Apt. 218</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carr Bailey Redmond</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel R. Logan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>--</b>		17. INFORMANT ADDRESS <b>Eva C. Desmond-Address same as #13 above.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cona</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>October 6, 1979</b> , to <b>Jan 3, 1982</b> , that (I) (we) last saw the deceased alive on <b>January 3, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Boo Weun Kim</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 4 1982</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boo Weun Kim</b>		22e. ADDRESS <b>8921 Shady Grove Court - Gaithersburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 7, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood-Prince Geo. Co.-Md.</b>		24. FUNERAL DIRECTOR <b>Jos. Gawler's Sons, Inc.</b> NAME ADDRESS <b>5130 Wisconsin Ave., N.W.-Wash., D.C.</b>				
25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles E. W. W. W.</b>				



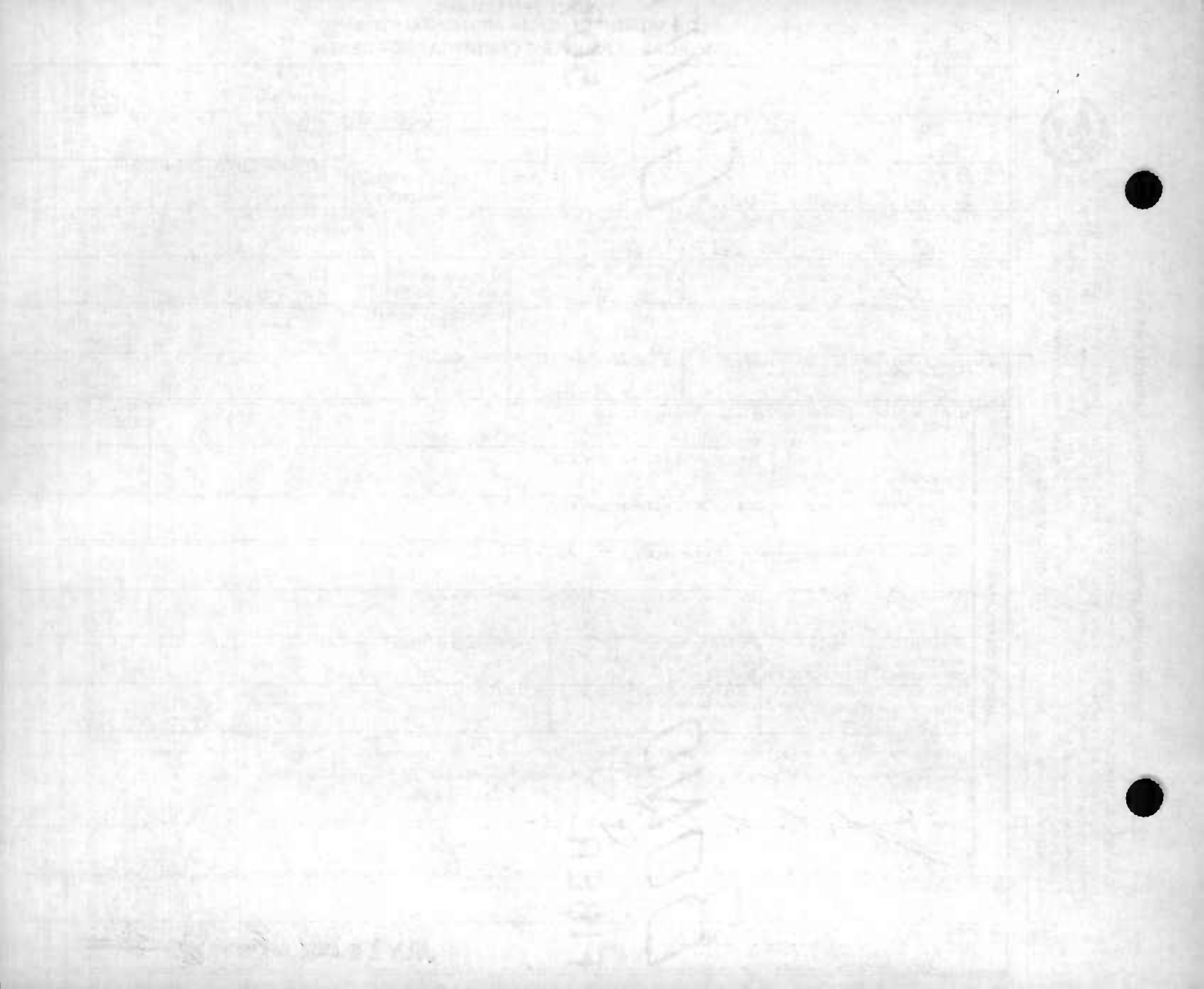
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR TO FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST RAYMOND		MIDDLE JOHN		LAST HEBDA		2a. DATE KNOWN OF DEATH ESTIMATED JAN 9, 1982		2b. HOUR 2:12 PM	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR OCT 25, 1952		6. AGE (IN YEARS) (LAST BIRTHDAY) 29 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD JAN 9, 1982		7d. HOUR 2:12 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2417 EVANS DRIVE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PHYSICIANS ASST.		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2417 EVANS DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD A. HEBDA						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANICE TALBERT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1972		16c. SOCIAL SECURITY NO. 215-46-1688		17. INFORMANT ADDRESS EDWARD A. HEBDA SAME AS 13 FATHER					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9554 IMMEDIATE CAUSE (a) GUNSHOT WOUND OF HEAD Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). NONE											
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:15 P.M. 1 9 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) SHOT SELF							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET EVANS DRIVE		CITY OR TOWN SILVER SPRING		COUNTY MONT		STATE MD.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY)											
ACTUAL SIGNATURE <i>John S. Rogers</i>						MEDICAL EXAMINER			DATE SIGNED		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS						ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/13/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN SILVER SPRING		COUNTY MONT		STATE MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR JAN 18 1982					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ethel Jean Helton</i>				2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Jan 10, 1982</i>				2b. HOUR MIN <i>1:53</i>											
3. SEX <i>FE.</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>APR. 27-21</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>60</i> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>Jan 10, 1982</i>		2d. HOUR MIN <i>1:53</i>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NO. CAROLINA</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD</i>							
10. CITY OR TOWN OF DEATH <i>Tak Park</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>North Alverton Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOUSEWIFE OWN HOME</i>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <i>MD</i>				13b. COUNTY <i>Montg.</i>				13c. CITY OR TOWN <i>Tak Park</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>8015 Greenwood Ave Apt 3</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>HARRISON PHILLIPS TEXA</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>GRIFFITH</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>242-12-5131</i>				17. INFORMANT ADDRESS <i>13801 ARDENNES BLVD</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Metastatic Carcinoma Brain</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Lung</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <i>None</i>																			
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) M.D. <i>Dep. MEDICAL EXAMINER</i>				DATE SIGNED <i>Jan 10, 1982</i>											
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>				ADDRESS <i>1919 SEMINARY RD. S.S. MD</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation.</i>				23b. DATE <i>1/11/82</i>				23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln</i>				23d. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Bladensburg Rd. P. G. Co.</i>							
FUNERAL DIRECTOR <i>Takoma Funeral Home.</i>				ADDRESS <i>254 Carroll St. N. W. D. C.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1982</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

MEDICAL CERTIFICATION

1900

*[Faint, mostly illegible handwriting and markings covering the upper and middle portions of the page. Some words like "Harrison" and "Principles" are faintly visible.]*

*[Faint handwriting at the bottom of the page, including what appears to be a date "Jan 2 1892" and other illegible notes.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 1 8 9 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Margaret C. Henderson</i>				January 12 82 12 59 PM			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 17 1926</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>55</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County MD.</i>	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Switchboard Oper.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Stowers</i>	
13a. STATE <i>Md.</i>				13b. CITY OR TOWN <i>Sil. Spr.</i>		13c. STREET ADDRESS <i>816 Easley Street</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Miller</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Alice McGee</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO. <i>131-20-4815</i>		17. INFORMANT ADDRESS <i>Robert M. Henderson 816 Easley St. Sil. Spr., Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia / Respiratory arrest</i> 2028 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days / 2 hrs</i> <i>6 mo</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <i>8</i> 19 <i>82</i> to <i>1/11</i> 19 <i>82</i> that (b) (we) last saw the deceased alive on <i>1/11</i> 19 <i>82</i> , and that (c) (my) (our) opinion of death occurred on the date and hour and from the causes stated above (If we did not view the body after death).							
22b. SIGNATURE <i>Peter B. Sherer</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>1/12/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PETER B. SHERER MD</i>				22e. ADDRESS <i>1109 Spring St. Silver Spring Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Jan. 13, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Metropolitan Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Alexandria, Va.</i>	
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey, Inc.</i>				P.O. Box 7428 <i>Sil. Spr., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1982</i>	
				25b. REGISTRAR'S SIGNATURE <i>Thomas Van Nuthan</i>			

MEDICAL CERTIFICATION

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9

1

2402 BP



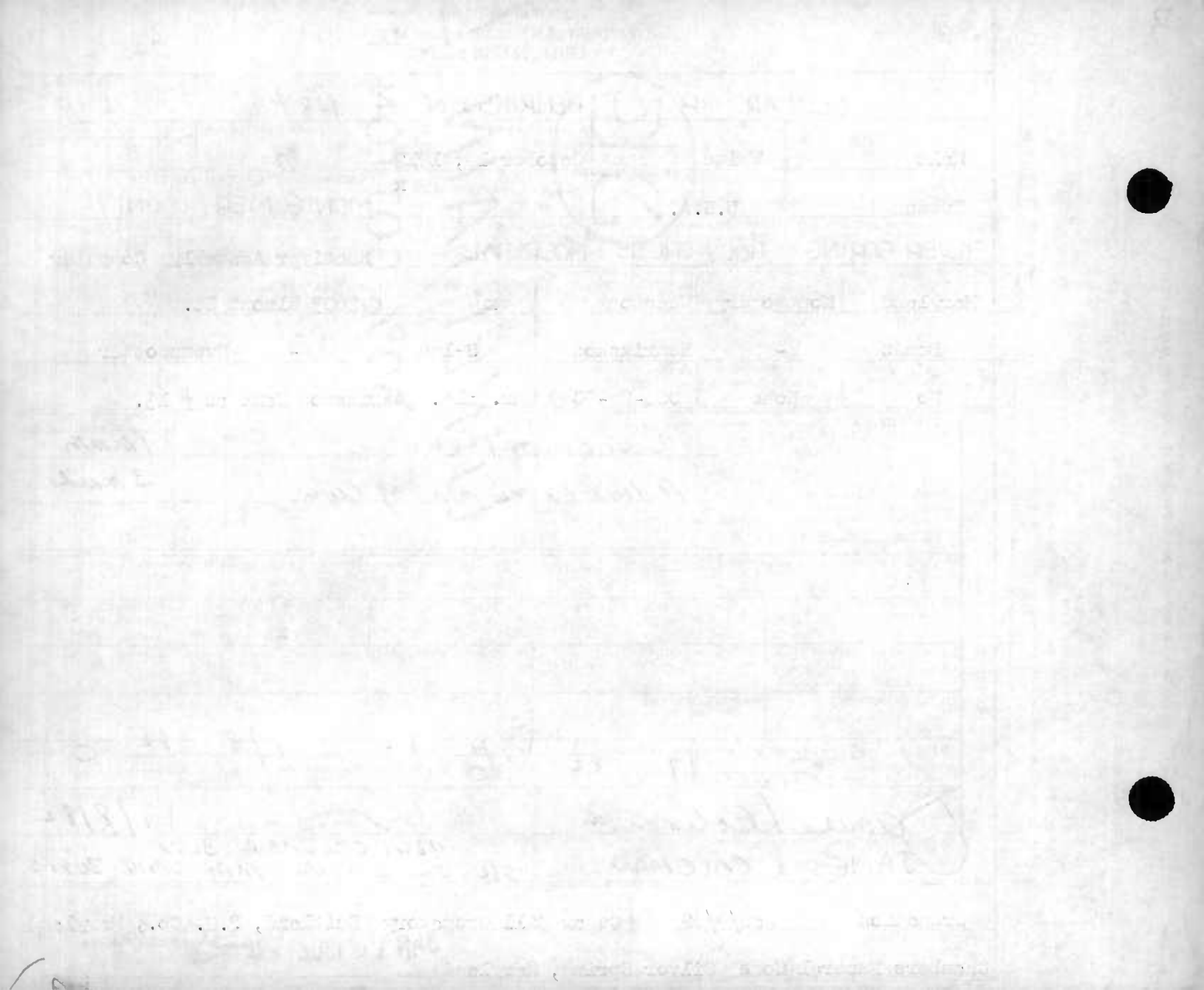
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202190			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GUNNAR B HENRIKSSON				2b. DATE OF DEATH MONTH DAY YEAR 1/8/82			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR October 18, 1912		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receiver Assembly		12b. KIND OF BUSINESS OR INDUSTRY Computer	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton	
14 FATHER'S NAME FIRST MIDDLE LAST Bendt - Henriksson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Selma - Svensdotter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT ADDRESS Gunnar B. Henriksson Same as # 13.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 1552 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Adeno carcinoma of liver</u> 3 months. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 3 months.
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 12/11/82 to 1/8/82, that (1) (we) lost saw the deceased alive on 1/7/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James R. Coleman M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/8/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES R COLEMAN				22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MARYLAND 20853.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan/9/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Co. Maryland	
24 FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Silver Spring, Maryland			





DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 0 2 1 9 1			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEROY HENRY</b>												2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>JAN 14 1982</b>		2b. HOUR OF DEATH MIN. <b>8:30</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 23 29 52</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>29 52</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>JAN 14 1982</b>		7d. HOUR OF DEATH MIN. <b>8:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>Pittsford</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PROGRAM ANALYST</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>			
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Pittsford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>13131 Cabinwood Dr</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEROY HENRY</b>						15. MOTHER'S MAIDEN NAME FIRST LAST <b>BERTHA JONE S</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR NAVY) <b>1950-1952</b>		16c. SOCIAL SECURITY NO. <b>587 38 7403</b>		17. INFORMANT ADDRESS <b>DOROTHY HENRY WIFE 13131 CABINWOOD DR. CABINWOOD DR.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Inf.</b> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Metastatic Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>															
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE <b>John Rogers</b>						TITLE (SPECIFY) M.D. <b>12 yr</b>		MEDICAL EXAMINER		DATE SIGNED <b>JAN 15 1982</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN ROGERS</b>						ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>JAN 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE, MD</b>					
24. FUNERAL DIRECTOR <b>ALEXANDER S. POPE</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>							



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 9 2

REG. NO.

1 - FOR  
STATE  
REGISTRAR

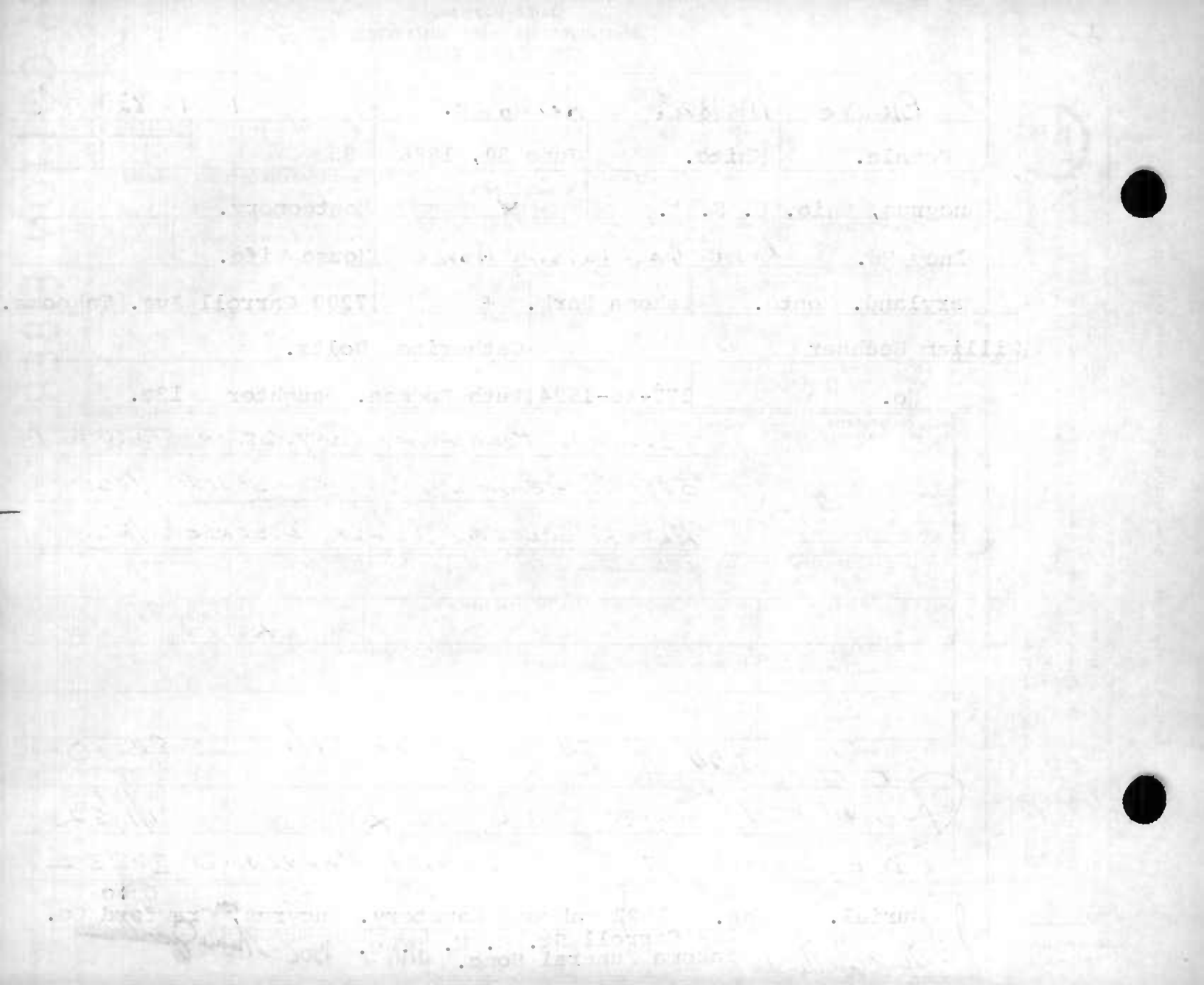
1. DECEASED NAME (TYPE OR PRINT) <b>Blanche Mildred Hermann.</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>82</b>		2b. HOUR <b>7:00</b> AM
3 SEX <b>Female.</b>	4 RACE <b>White.</b>	5 DATE OF BIRTH MONTH <b>June</b> DAY <b>30</b> YEAR <b>1886</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bucyrus, Ohio.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery.</b> MD.		
10 CITY OR TOWN OF DEATH <b>Olney Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brook House Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife.</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland.</b>	13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>Takoma Park</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7200 Carroll Ave. Takooma.</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Beehner</b> LAST <b></b>			15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b>Boltz.</b> LAST <b></b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>277-46-1594</b>		17. INFORMANT ADDRESS <b>Ruth Redman. Daughter 13e.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PULMONARY CONGESTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 DAYS.</b>
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last	b) DUE TO, OR AS A CONSEQUENCE OF <b>ORGANIC BRAIN SYNDROME - SEVERE</b>	<b>YES -</b>
	c) DUE TO, OR AS A CONSEQUENCE OF <b>ARTERIOSCLEROTIC VASC. DISEASE</b>	<b>YES</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>2/1/82</b> to <b>1/1/82</b> , that (1) (we) last saw the deceased alive on <b>12/24</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.			
22b. SIGNATURE <b>Donald R. Lewis</b>		DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>1/1/82</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. R. LEWIS, M.D.</b>		22e. ADDRESS <b>OLNEY, MARYLAND 20832</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial.</b>	23b. DATE <b>Jan. 1982</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Bucyrus</b> COUNTY <b>Crawford Co.</b> STATE <b>Ohio</b>
24. FUNERAL DIRECTOR <b>Robert J. Kellers</b>		25. DATE REC'D. BY REGISTRAR <b>JAN 5 1982</b>	
25a. ADDRESS <b>254 Carroll St. N. W. Takoma Funeral Home.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 1 9 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELOISE MARY HERRING</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 6, 1982</b>			2b. HOUR <b>12:30 p</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 3, 1903</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>78</b>	IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 74 HRS. HOURS MIN. <b>MD</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>PRINCE GEO.</b>		13c. CITY OR TOWN <b>ADELPHI</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDGAR S. EDWARD</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA JANE SWINN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>579-22-5240</b>		17. INFORMANT <b>DAUGHTER GERTRUDE E. SWETNAM: ADELPHI, MARYLAND</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2030</b> IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>23 DECEMBER 1981</b> , to <b>06 JANUARY 1982</b> , that (I) (we) last saw the deceased alive on <b>06 JANUARY 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>H. L. Reed</i> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1-6-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>H. L. REED, LT, MC, USNR</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/9/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NANCY HART MEMORIAL PK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>HARTWELL HART GEORGIA</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



28-1-1

28-1-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be delivered for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 0 2 1 9 4 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Peggy Colville Hicks</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>01 29 82</b>			2b. HOUR <b>6:30 pm</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MO. DAY YEAR <b>Mar. 9 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lanark, Scotland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill-Bethesda Cedar Lane 5215</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>Wash., D. C.</b>						13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>4000 Mass Avenue, N. W.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Graham</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Colville</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>215-46-2583</b>		17. INFORMANT ADDRESS <b>Sheila Tilbury 137 N Carson Rd., Hills Calif. Beverly</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <b>None</b>										
9a. DATE OF OPERATION <b>Dec. 1981</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Metastatic carcinoma of breast</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 26</b> , 19 <b>82</b> , to <b>Jan. 29</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan. 26</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE <b>John B. Umkehr MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/29/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John B. Umkehr MD</b>						22e. ADDRESS <b>8805 Comp. Ave. Chevy Chase Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/5/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington V. 20815</b>				
24. FUNERAL DIRECTOR NAME <b>Joseph &amp; Weller's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR (IN REGISTRY) <b>FEB 4 1982</b>				





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 9 5

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Claude H. Hill			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1982			2b. HOUR P M 6:10 P M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 3, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 18812 Walker Choice Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator		12b. KIND OF BUSINESS OR INDUSTRY Golf Club			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Clyde Hill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Curtin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II			16b. SOCIAL SECURITY NO. 325-26-3347		17. INFORMANT Eleen F. Hill.			ADDRESS Same as #13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHADDER ARREST. COMPLETE AV BLOCK DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION. POST BY POST SURGERY STATION DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC HEART DISEASE 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2 YEARS 10 YEARS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CHRONIC PULMONARY DISEASE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from July 5, 1976, to January 18, 1982, that (I) (we) lost saw the deceased alive on January 18, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Gregorio Kays				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GREGORIO KAYS				22e. ADDRESS 13 E DEEP PARK DR GAITHERSBURG MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 2, '82		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 8 1982		25b. REGISTRAR'S SIGNATURE Ramon Juan Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202196			
1. DECEASED NAME (TYPE PRINT) <b>Francis W. Hill</b>				2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>Jan. 17 1982 11:45 P.M.</b>			
1. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 2 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>	
7a. PLACE OF BIRTH <b>Upper Marlboro Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10. CITY OR TOWN OF DEATH <b>Chevy Chase Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5826 Highland Drive Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lawyer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Legal</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis W. Hill Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Claret</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-10-9262</b>	
17. INFORMANT NAME ADDRESS <b>Margaret R Hill 5826 Highland Dr 2nd Md</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic brain syndrome</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic brain disease - gas.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>nos.</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1980</b> to <b>1/17/82</b> , that (II) (we) lost saw the deceased alive on <b>1/17/82</b> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (II) (we) did (I) did not view the body after death.							
22b. SIGNATURE <b>Bernard J. Walsh Sr.</b>		22c. DATE SIGNED <b>1/18/82</b>		22d. PHYSICIAN'S NAME (TYPE PRINT) <b>Bernard J. Walsh</b>		22e. ADDRESS <b>5700 Miss. Ave. - Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1-18-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Georgetown Med School</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Metropolitan Funeral Service, Alexandria, Va.</b>				25a. DATE REC'D. BY REGISTRAR (25b. REGISTRAR'S SIGNATURE) <b>JAN 26 1982</b> <b>James Santhorn</b>			

White

ATV and Monksomely Chevy Chase x 3815 Highland St.

St.

No

Removal 1-18-82 Georgetown High School Washington, D.C.

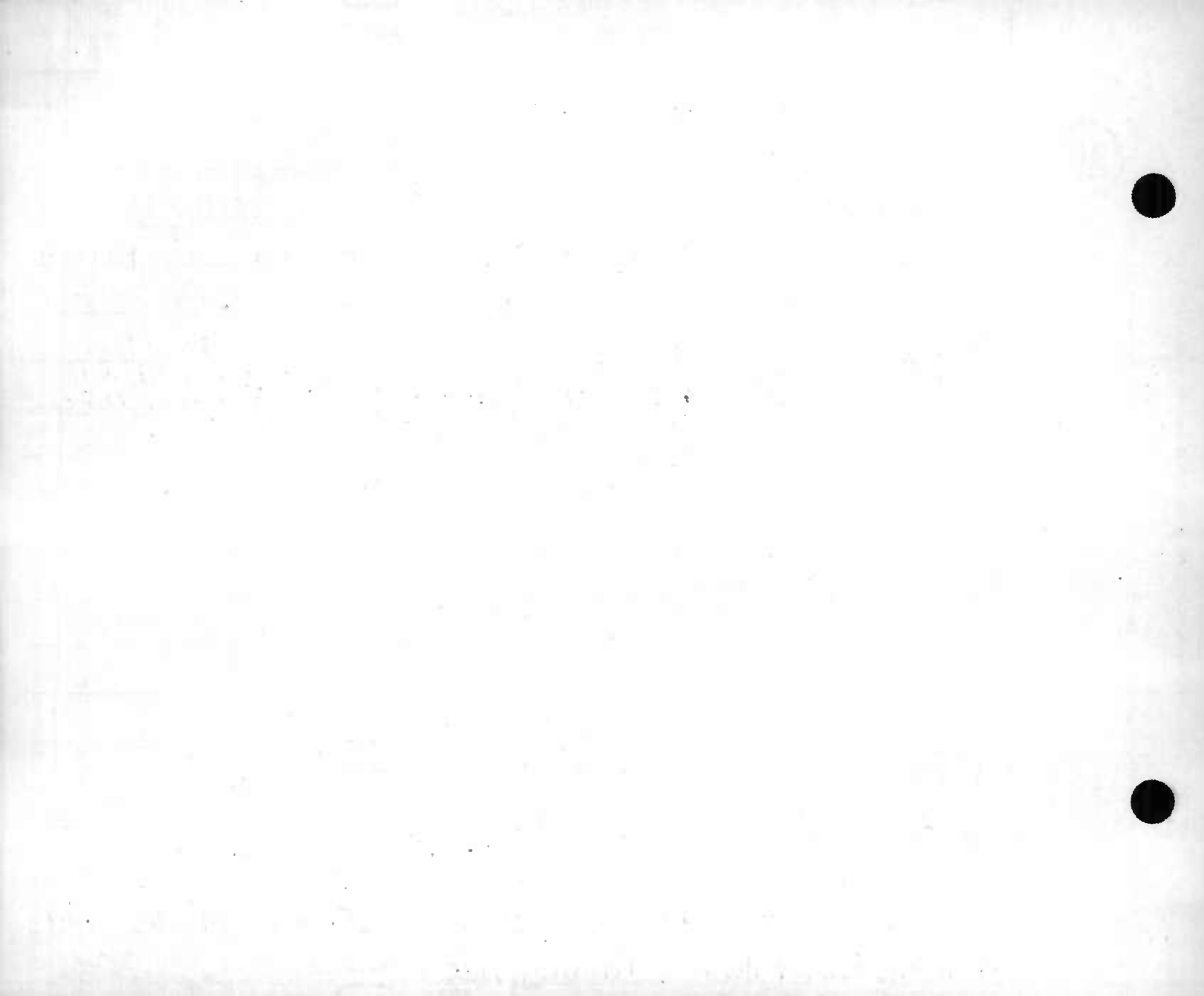
Metropolitan Funeral Service Alexandria, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 1 9 7					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
THOMAS Alexander HILL								1 5 82					545 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 2 HRS					
M		BLACK		MONTH 12 DAY 9 YEAR 00		81 YRS		MONTHS		DAYS		HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		USA				MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		BEL PRE HEALTH CARE CTR.										Farmer		Private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
D. C.		NA		NA		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4800 FT. TOTEN DRIVE							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
George		Caroline													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, YES; NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT											
YES		IWW II		Frances Hill 4042 Grant St. N.E. Washington, D.C.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 5850												4 days			
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure												Monthly			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
Hypertension															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR													
		P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from 8/2/82 to 1/5/82, that (I) (we) last saw the deceased alive on 1/2/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED									
R.T. Benack MD						1/5/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
R.T. Benack MD		4115 Colie Dr. Wheaton, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
Burial		1-9-82		Holy Ghost Church		Issue		Charles		md.					
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Thornton's Funeral Home				Pomonkey, Md.		JAN 11 1982		Frances Jan. Nathan							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 1 9 8

FOR  
1. STATE  
REGISTRAR

Mary T. Hindman

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY T. LAST HINDMAN		2a. DATE OF DEATH MONTH DAY YEAR Jan 17 '82		2b. HOUR 1149 A
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 05 27 91		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 13b. COUNTY None		13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Alfred MIDDLE L. LAST Thomas		15. MOTHER'S MAIDEN NAME FIRST Fanny MIDDLE May LAST Kannon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-42-4826		17. INFORMANT ADDRESS Rockville Virginia H. Mann 9312 Overlea Dr. Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 5 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) the hospital attended the deceased from July 81 to 1/17/82 that (b) (we) last saw the deceased alive on 1/15/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (c) (d) (e) view the body after death.			
22b. SIGNATURE THOS G. WARD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1/17/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOS G. WARD		22e. ADDRESS 6116 ROBINWOOD, Bethesda, Md 20817	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial - Removal	23b. DATE 1/20/82	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION Columbus, Maury County Tenn Maury, Tenn.
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR JAN 27 1982	25b. REGISTRAR'S SIGNATURE [Signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.



2

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

11 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

12 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) MRS <del>ANNE</del> MARIE HOCKING		2a DATE OF DEATH MONTH DAY YEAR January 28 1982		2b HOUR 1:45 P.M.	
3 SEX Female	4 RACE white	5. DATE OF BIRTH MONTH DAY YEAR Feb. 12 1932		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 107 Lillian Street,		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b KIND OF BUSINESS OR INDUSTRY Catholic High School
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a STATE Maryland	13b COUNTY Montgomery	13c CITY OR TOWN Silver Spr.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 107 Lillian Street,	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Winston		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice J. Reardon			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b SOCIAL SECURITY NO. 578-42-7925		17 INFORMANT ADDRESS William Hocking- husband- (same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) <u>FLUID &amp; ELECTROLYTE IMBALANCE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>WIDESPREAD EFFECTS OF CARCINOMA</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>6 WKS</u> <u>18 MO</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>81</u> to <u>1/28</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Richard P. Delaney, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard P. Delaney, M.D.		22e. ADDRESS 4323 Havard Street, Silver Spring, Md. 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN COUNTY STATE Sil. Spring Montgomery Md.					
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Sil. Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 4 1982	
		25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u>			

BP



NOV 19 1954



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 2 0 2 2 0 0					
1. FOR STATE REGISTRAR						REG. NO.					
1 DECEASED NAME (TYPE OR PRINT) <b>Frank Sautler Hofues, Jr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 28, 1982</b>				2b. HOUR <b>9:59</b> P.M.	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>real</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>estate</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>532 W. Deer Park Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Sautler Hofues, Sr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cameal Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>				16b. SOCIAL SECURITY NO. <b>WW II 458-07-2391</b>		17. INFORMANT ADDRESS <b>Calif. John G. Thorpe 800 Wilshire Blvd. Los Angeles</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerotic Heart Disease</b>										14 years	
(c) <b>with Myocardial Infarct &amp; Congestive Heart Failure</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>November 19 1968</b> to <b>28 January 19 1982</b> , that (I) (we) last saw the deceased alive on <b>7 December 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Michel Healy</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michel Healy</b>						22e. ADDRESS <b>5652 Shields Drive Bethesda, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/9/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dallas Dallas Texas</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> NAME ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

24. FUNERAL DIRECTOR **Tyson Wheeler Funeral Home, Inc.**  
NAME ADDRESS **1331 Rockville Pike Rockville, Maryland**

25a. DATE REC'D. BY REGISTRAR **FEB 4 1982**  
25b. REGISTRAR'S SIGNATURE **James J. [Signature]**

1981 Rockville Pike Rockville, Maryland  
 Tyson Wheeler Funeral Home, Inc.  
 11111 Rockville Pike  
 Rockville, Maryland 20851

Michael Neely 2055 Ashland Drive Bethesda, Maryland

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 0 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>CATHERINE LOUISE BROWN HOGAN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>01/10/82</b>		2b HOUR <b>4:55p</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8<sup>th</sup> 21<sup>st</sup> 1915</b>		
6 AGE (IN YEARS LAST BIRTHDAY) <b>66</b>		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Olney, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Treasurer</b>		
12b KIND OF BUSINESS OR INDUSTRY <b>Montg. Ins.,</b>		13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
13b STATE <b>Maryland</b>		13c CITY OR TOWN <b>Montgomery Ashton</b>		13d STREET ADDRESS <b>7700 New Hampshire Avenue.</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>George F. Brown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Ada Thompson</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-07-6667</b>		17 INFORMANT ADDRESS <b>Melvin A. Hogan-husband (same as 13e)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of colon with metastasis</b> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Mar</u> , 19 <u>81</u> , to <u>Jan 10</u> , 19 <u>82</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>Jan 9</u> , 19 <u>82</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.						
22b SIGNATURE <b>Eugene P. Flannery MD by Frederick Moomau, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-10-82</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene P. Flannery by Frederick Moomau, MD</b>		22e ADDRESS <b>18111 Pr. Philip Dr., Olney, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-14-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtonsville Montgomery Md.</b>		23e. DATE RECD. BY REGISTRAR <b>JAN 14 1982</b>				
23f. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>		23g. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

29

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Funeral Director  
**Hines/Rinaldi Funeral Home**  
1800 N.H. Ave.,  
Silver Spring, Md.

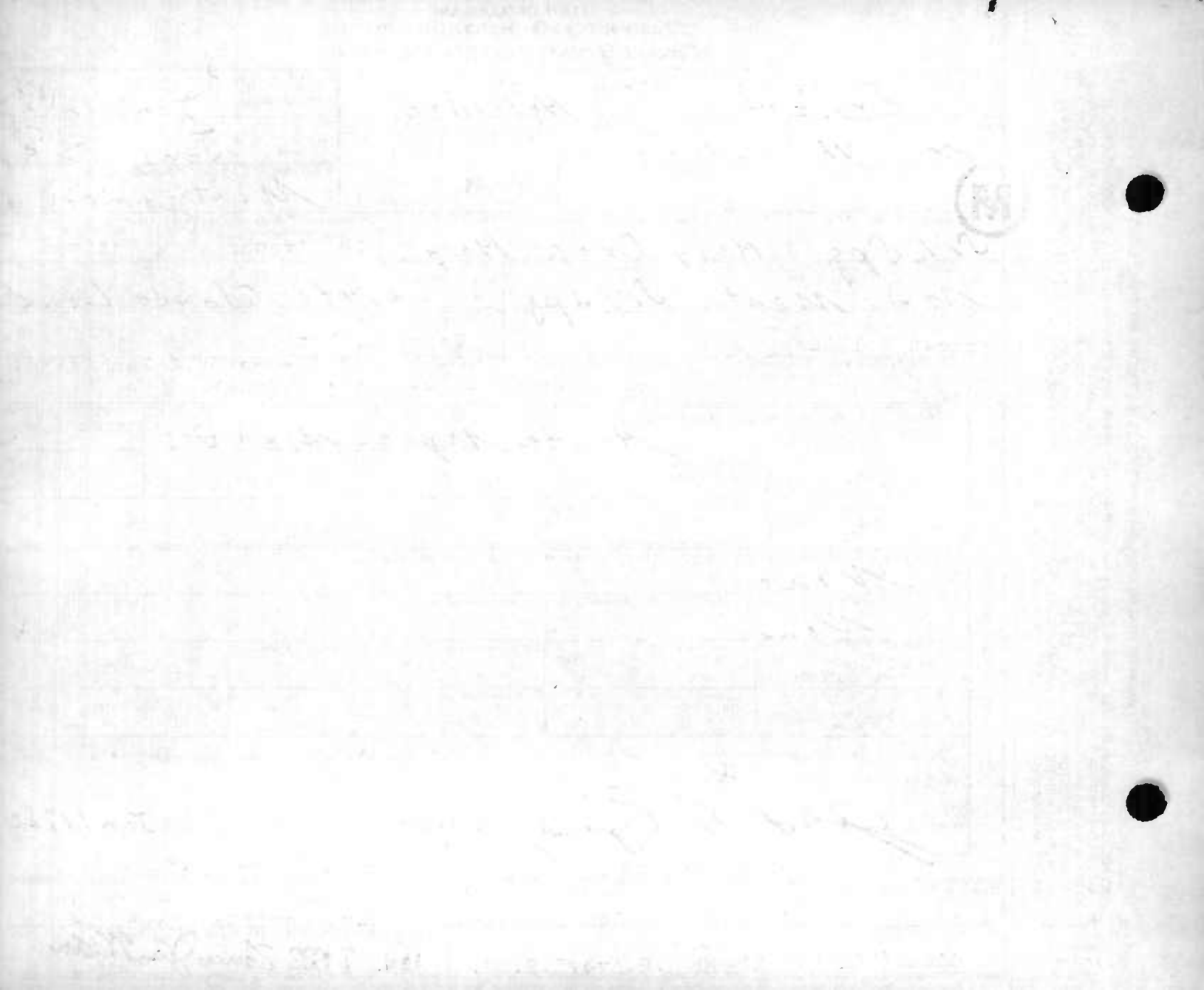






TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 2 0 2	
1. DECEASED NAME (TYPE OR PRINT) <b>Ernest Milton Hollidge</b>										2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>Jan 1 19 82</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 18 1912</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Jan 1 19 82</b>		7b. HOUR <b>10:50 A</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Pitt Spg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <b>DC Fireman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Pitt Spg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>14887 Claude Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Hollidge</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl L. Chapple</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>None</b>				16b. SOCIAL SECURITY NO. <b>578 10 6785</b>		17. INFORMANT <b>6009 Jerry Dr. Columbia, Md.</b> <b>Ernest Hollidge (Son)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>						TITLE (SPECIFY) <b>M.D. Chap</b>		MEDICAL EXAMINER		DATE SIGNED <b>Jan 1, 1982</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>						ADDRESS <b>1919 Seminary Rd. S.S. Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/4/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burtonsville Mont. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b> ADDRESS <b>11800 N.H. Ave. S.S. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Jan Thorton</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 10 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 2 0 3	
1. DECEASED NAME (TYPE OR PRINT) <b>Vertell Thomas Holloway</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>1-23 1982</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>Oct. 7, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>Jan 23 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>D.C.</b>			13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>Washington</b>			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>3804 S. Cap. St., S.E. #202</b>	
14. FATHER'S NAME <b>John M. Govan</b>						15. MOTHER'S MAIDEN NAME <b>Reatha B. Cleckley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mack Govan-805 Painter Pl Hgts.</b>			ADDRESS <b>District</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5860 Hypertensive Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Asthma - Chronic -</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b> M.D. MEDICAL EXAMINER				DATE SIGNED <b>Jan 23 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN G. BALL</b>				ADDRESS <b>7936 Old Georgetown Rd. Bethesda Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>1-27-82</b>				23b. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>				23c. LOCATION <b>Landover P.G/Md</b> COUNTY STATE			
24. FUNERAL DIRECTOR <b>H.S. Washington</b>				ADDRESS <b>4925 Burroughs Ave N.E.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1982</b>			
								25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

BP



James Black 1001 7/12/52

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 0 4			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST <b>Anna nmn Holota</b>				2b. HOUR a. <b>4:45</b> M.			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 1997</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>84</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Potomac</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11717 Karen Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13e. STREET ADDRESS <b>11717 Karen Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Wols</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anastasia Warsholak</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>191-05-3366</b>		17. INFORMANT ADDRESS <b>James Holota same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>complete heart block</b> (c) <b>arteriosclerotic cardiovascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>probable terminal pneumonia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>82 Sept. 27</b> , 19 <b>74</b> , to <b>Jan. 15</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 5</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (us) view the body after death.							
22b. SIGNATURE <b>John D. Griswold</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/15/82</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John D. Griswold</b>	
22e. ADDRESS <b>4830 V st. Washington, D.C. 20007</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Butler Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b>				25. REG. D. BY REGISTRAR <b>JAN 20 1982</b>			
24. ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>							

1331 Rockville Pike  
Tynon Wheeler Funeral Home, Inc.  
Rode Hill Cemetery  
Butler

John D. Griswold

4830 V St. Washington, D.C. 20007

1/12/82

Jan. 5

Sept. 27

74

Jan. 12

82

probable terminal pneumonia

arteriosclerotic cardiovascular disease

complete heart block

cardiac arrest

191-05-3566 James Holton was an 13e

James Holton Anastasia

Maryland Montgomery Potomac

Potomac 11717 Karen Drive

Montgomery Potomac

U.S.A. X

Montgomery

1897 2 1897 24

Ann Montgomery Holton

Jan. 12, 1982 1/12/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 0 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELLA P HOOK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 17 82</b>			2b. HOUR <b>12 45 PM</b>			
3 SEX <b>F</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-16-1883</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>99</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>HOWARD, MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Olney, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brooke Grove Nsg/Hme</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>govt. clerk.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLERK.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3420 16th St Wash. D.C. N.W.</b>	
14. DECEASED'S NAME FIRST MIDDLE LAST <b>Richard P. PUE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Francis Benson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Richard P. PUE, Highland, Md 20777</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Transition</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Oxytocin Poison Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASVD.</b>		INTERVAL BETWEEN DEATH AND DEATH <b>5 hr</b> <b>5 hr</b> <b>5 hr</b>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/1/82</b> 19 <b>82</b> to <b>1/17</b> 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C.H. Ligon</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.H. Ligon</b>		22e. ADDRESS <b>1814 P &amp; Phipps St., Olney Md 20832</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATE</b>		23b. DATE <b>1-18-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW MEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATERVILLE BALTO. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Slack F.H. Elliott City, Md 21043</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>Thomas J. ...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200

RELEASED BY CORNER 1/19/82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 0 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HANNAH - HOPEWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11/19/82</b>		2b. HOUR <b>7:19 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 16, 1898</b>		
7a. BIRTHPLACE (STATE OR FOREIGN) <b>JAMAICA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY - STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>		
12a. USUAL RESIDENCE (IF NURSING HOME - OTHER INSTITUTION, - RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G.CO.</b>		13c. CITY OR TOWN <b>LANHAM</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		12b. USUAL OCCUPATION (TYPE, WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>118-18-3803</b>		17. INFORMANT ADDRESS <b>RENAUD B. MITCHELL (SON) SAME AS # 13.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 2500 } DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> 17 DAYS (c) <b>DIABETIS</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>UREMIA</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
22a. I certify that (I) <del>viewed</del> attended the deceased from <b>JAN 2</b> , 19 <b>82</b> , to <b>19 JAN</b> , 19 <b>82</b> , that (I) <del>viewed</del> just saw the deceased alive on <b>19 JAN</b> , 19 <b>82</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>viewed</del> did not view the body after death.						
22b. SIGNATURE <b>Walter E. Gooch MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>20 JAN 82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER E. GOOCH MD</b>		22e. ADDRESS <b>2309 SHOREFIELD RD WHEATON MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL PARK LANDOVER, P.G.CO., MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>		ADDRESS <b>RIVERDALE, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		
				25b. REGISTRAR'S SIGNATURE <b>C. J. Nathan</b>		

MEDICAL CERTIFICATION



11/10/20  
KAREN A. GUNN

11/10/20

11/10/20

11/10/20

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11/10/20

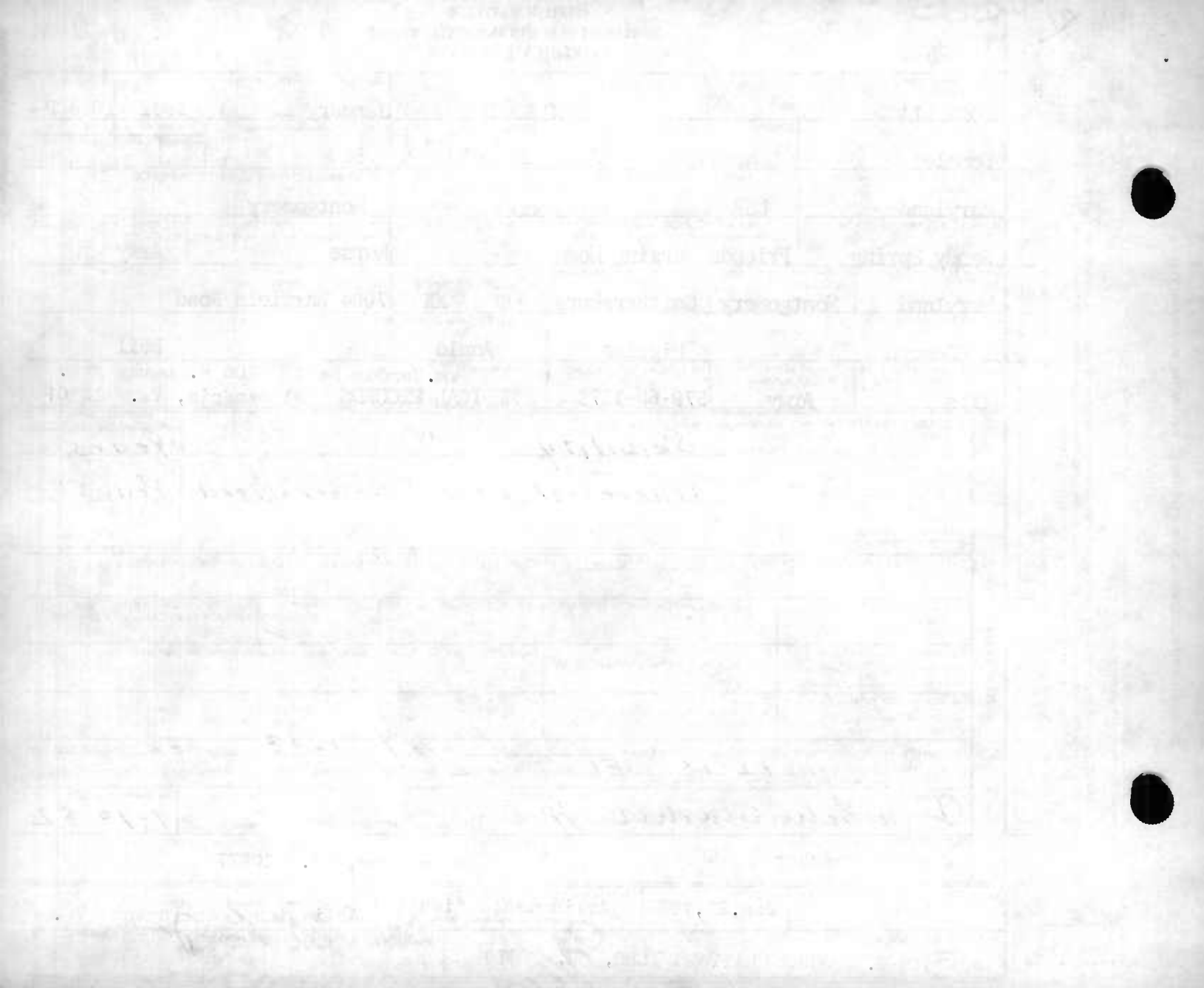
11/10/20

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 0 7			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORNELIA H. HOWARD				2b. DATE OF DEATH MONTH DAY YEAR January 18 1982			
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 22, 1890		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Sandy Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Friends Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Army	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Gaithersburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 7004 Warfield Road			
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Higgins				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Bell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army 579-60-1379		17 INFORMANT Wm. Gordon Bell ADDRESS 206 E. Luray Ave. MEDICAL RECORDS Alexandria, Va. 22301			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Senility 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years Years							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 47 to 1-18-1982, that (I) (we) last saw the deceased alive on 12-13-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE DEGREE Jack Schumacher M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-19-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack Schumacher MD				22e. ADDRESS Gaithersburg, Md. 20877			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Jan. 21, 1982		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.	
24 FUNERAL DIRECTOR NAME FRANCIS H. BARBER				24b. ADDRESS LAYTONSVILLE, MD. 20879			
25. I hereby certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DMMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 0 2 2 0 8			
1. FOR STATE REGISTRAR					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>VIRGINIA P HOWARD</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 19 82</b> 2b. HOUR <b>4:01 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 7, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Home Nursing</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b> 13a. COUNTY <b>N/A</b>		13b. CITY OR TOWN <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>5011 44th Street, N.W.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Prince</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dosier D. Watkins</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>579 22 7362</b>				
17. INFORMANT <b>William M. Howard</b>		17. ADDRESS <b>8412 Kingsgate Road Potomac, MD 20854</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Circulo. respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Generalized arteriosclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>16 yrs</b> <b>20 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 82</b> to <b>19 JAN 19 82</b> , that (I) (we) last saw the deceased alive on <b>15 Nov 19 81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.								
22b. SIGNATURE <b>[Signature]</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/19/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John M. Wynn M.D.</b>		22e. ADDRESS <b>7801 Northall Ave Bethesda MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 22, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Potomac Methodist Church Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Potomac, Maryland</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b> <b>Homes, P.A. Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b> 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				



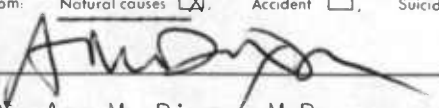

*[Faint, illegible handwritten text]*



Items 5, 6 g564 2/2/82 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 0 2 2 0 9

1. DECEASED NAME (TYPE OR PRINT) <b>Jimmie C. IRVIN</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 28 1982</b>		2b. HOUR M <b>6:40</b>
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1938</b>	6. AGE (IN YEARS) LAST BIRTHDAY TRS. <b>44</b>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>42</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>College Park</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Jake Irvin</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Coffman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Discounter</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>226-48-6258</b>		17. INFORMANT <b>Brenda Lee Irvin</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER		DATE SIGNED <b>1-28-82</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridge Lawn Cemetery</b>
24. FUNERAL DIRECTOR NAME <b>F. Casch's Sons</b>		ADDRESS <b>F.H. P.A. Hyattsville, Maryland</b>		25a. DATE RECEIVED BY REGISTRAR <b>FEB 1 1982</b>
25b. REGISTRAR'S SIGNATURE 		25c. REGISTRAR'S NAME <b>Smythe Virginia</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

July 10, 1944



Received  
of the  
amount of  
\$100.00

John J. Levin

1-1-1944

John

John

*[Handwritten signature]*

Received of the amount of \$100.00  
John J. Levin  
1-1-1944

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 1 0

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ISADORE NMN ISAAC</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 24 82</b>			2b. HOUR <b>5 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WH ITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 23, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery CO. MD.</b>			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SHADY GROVE ADVENTIST HOS P.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GROCE R</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MARYLAND</b> 13c. CITY OR TOWN <b>BALTIMORE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>APT. 203 6520 EBERLE DR. #21215</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>DAVID ISAACS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>REBECCA ROSENBERG</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>219-10-3526</b>		17. INFORMANT <b>MR. JOEL ARONSON</b> <b>35 TREEWORTHY RD., GAITHERSVILLE, MD 20878</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTRO MECHANICAL DISSOCIATION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> 19 <b>82</b> to <b>1/24</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Mark F. Weinstein M.D.</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/24/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK F. WEINSTEIN, M.D.</b>						22e. ADDRESS <b>ROCKVILLE, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JAN. 25, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI REUBEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO. MD</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>		25b. REGISTRAR <b>Frances Jan Nathan</b>	

Electrocardiogram  
Heart rate 100 bpm  
Interpretation: Normal



1/11/11 11:11 AM

1/11/11 11:11 AM

JAN 11 2011

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 1 1					
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA</b>				LAST <b>ISAACSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 13, 1982</b>				2b. HOUR <b>11:00AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 23, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASHINGTON</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6121 Montrose Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Schwartz</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Golda Guttman</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>058-22-4911</b>	
17. INFORMANT ADDRESS <b>1612 Crestline Road, Silver Spring, Md. 20904</b>				18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis Shock</b> <b>5739</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hepatic infection?</b> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/8/79</b> 19 <b>79</b> to <b>1/13/82</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/12/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>H.D. Khianey</b>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/13/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HIRSH D. KHIANEY</b>				22e. ADDRESS <b>6121 MONTROSE ROAD, ROCKVILLE, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/15/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISRAEL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY <b>WOODBRIDGE, MIDDLESEX, NEW JERSEY</b>					
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Van Natten</b>					
232 CARROLL STREET, N. W., WASHINGTON, D. C.													

January 1, 1900



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

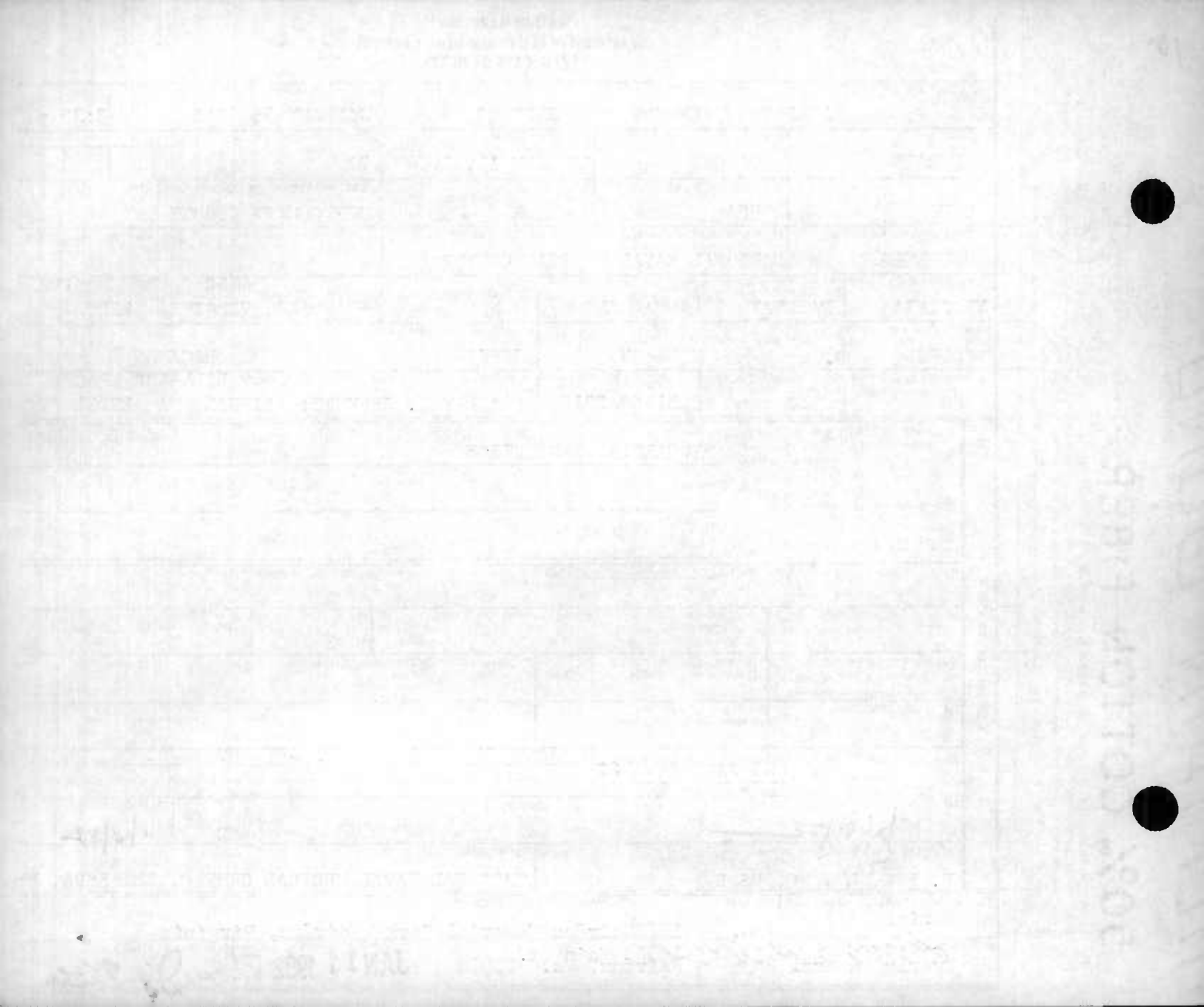
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRIET KENNEDY JEFFERS</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5, 1982</b>		2b. HOUR <b>2:35 p.m.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 11, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>ANNANDALE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE H. KENNEDY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JESSIE HAGAMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NO</b>		17. INFORMANT <b>8609 HILLSIDE PLACE</b> <b>STANLEY K. JEFFERS: FAIRFAX, VA 22031</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>04 JANUARY 1982</b> to <b>05 JANUARY 1982</b> , that (I) (we) lost saw the deceased alive on <b>05 JANUARY 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>K. Lee</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>1/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. LEE, LT, MC, USNR</b>		22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairfax Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairfax, Virginia</b>			
24. FUNERAL DIRECTOR <b>Everly Funeral Home</b>		10565 Main St. <b>Fairfax, Va. 22030</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Frances Jean Nathan</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 2 1 3							
1- FOR STATE REGISTRAR		REG. NO.															
1 DECEASED NAME (TYPE OR PRINT)		FIRST BARNEY		MIDDLE M.		LAST JETT		2a. DATE OF DEATH		MONTH 1		DAY 11		YEAR 82		2b. HOUR 0530 M	
3. SEX MALE		4. RACE C		5 DATE OF BIRTH		MONTH SEPT		DAY 1		YEAR 1909		6 AGE (IN YEARS LAST BIRTHDAY) 71		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Golf course		12b. KIND OF BUSINESS OR INDUSTRY											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Poolesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 13325 Rileys Lock Rd.							
14 FATHER'S NAME		FIRST Walter		MIDDLE		LAST Jett		15 MOTHER'S MAIDEN NAME		FIRST Pearl		MIDDLE		LAST Gravley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Mrs. Margaret Bennett		ADDRESS Poolesville Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4280 Congestive Heart + Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from Jan 07 82, 19 to Jan 10 1982, that (I) (we) lost saw the deceased alive on Jan 10 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Hector Asuncion MD																22c. DATE SIGNED 1/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HECTOR ASUNCION, M.D.																22e. ADDRESS 19601 Fisher Ave. Poolesville, MD 20837	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/82		23c. NAME OF CEMETERY OR CREMATORY Cheltenham VA.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Md.											
24 FUNERAL DIRECTOR NAME W.C. Miller																25a. DATE RECD. BY REGISTRAR JAN 20 1982	
ADDRESS Baltimore Md. 20838																	



Received of the University of Chicago  
the sum of \$100.00  
for the purchase of books  
on the 10th day of May 1910  
by the Librarian  
J. H. Johnson

For the sum of \$100.00  
on the 10th day of May 1910  
the sum of \$100.00  
for the purchase of books  
on the 10th day of May 1910  
by the Librarian  
J. H. Johnson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 1 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR	
Hilda Christina		JOHNSON		January 12, 1982		9:10A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Feb. 21, 1896		85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Penna.		USA				Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Damascus		10517 Bethesda Church Rd.		Nurse			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13e. STREET ADDRESS	
Maryland		Montgomery		Damascus		10517 Bethesda Church Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
Anders Johnson		Ida unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		198-24-8990		Betty Klose, Item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>ATRIAL FIBRILLATION</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c) <u>SEVERE HYPERTENSION</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
<u>RECENT STROKE, HYPERHYPERTHYROID, THYROID NODULE.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>81</u> , to <u>1/12</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> Just saw the deceased alive on <u>1/12</u> , 19 <u>81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.		22b. SIGNATURE <u>Kenneth J. Weiss</u>		DEGREE <u>MD.</u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
Kenneth J. Weiss, M.D.		26250 Ridge Rd., Damascus, Md. 20872		Jan. 12, 1982			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Jan. 16, 1982		Monongahela		Braddock, Penna.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth, P.A., Address, Damascus, Md.		JAN 18 1982		<u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 1 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROWENA JEAN JOHNSON				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1982		2b. HOUR 7:05 A.M.	
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 01, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS. MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VA 13b. COUNTY MIDDLESEX 13c. CITY OR TOWN SALUDA				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. BOX 427, SALUDA VA	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE DEWEY CHANDLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GERTRUDE BROOKS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A 246-32-0782		17. INFORMANT ADDRESS HUSB, WALTER JOHNSON, P.O. BOX 427, SALUDA VA			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) ADENOCARCINOMA, UNKNOWN PRIMARY POSSIBLY 1991 VA, METASTASIS TO LUNGS DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 26 DEC 1981, 19_____, to 14 JAN 1982, that (I) (we) last saw the deceased alive on 14 JAN 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>J.M. Reed</i> DEGREE				22c. DATE SIGNED 1/14/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.M. REED, CAPT MC USN	
22e. ADDRESS NATNAVMEDCEN BETHESDA MD				22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 19 82		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.	
24. FUNERAL DIRECTOR NAME <i>Wayne F. F. Reed</i> ADDRESS Demaine Funeral Homes, Inc., Alex., Va. 22314				25a. REG'D. BY REGISTRAR JAN 10 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

BP \_\_\_\_\_

12-14-1918



12-14-1918

RECEIVED  
MOTOR CO.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

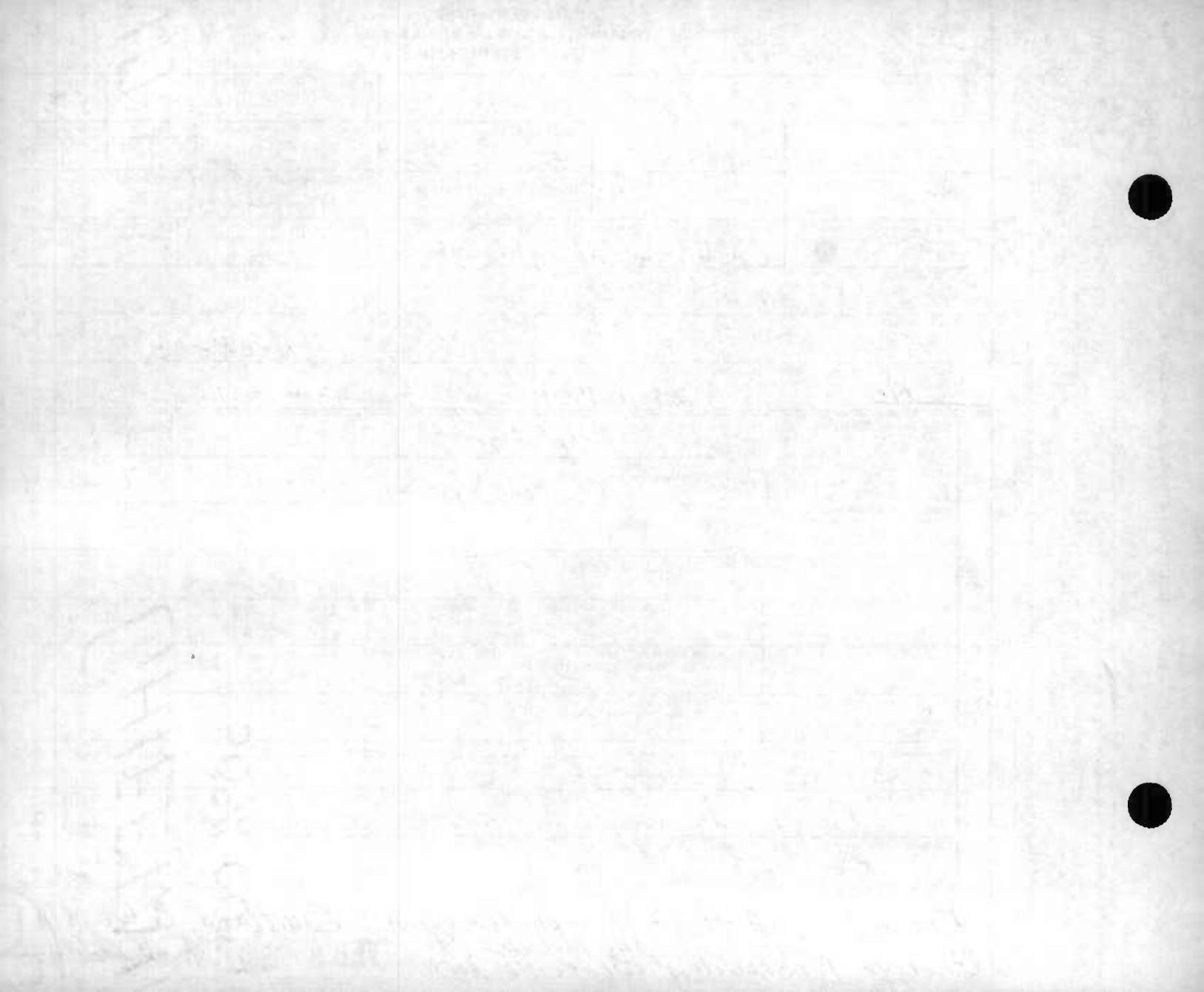
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1 - STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE M. LAST Jones					2a. DATE OF DEATH MONTH 11 DAY 31 YEAR 82					2b. HOUR 8:30 P.M.
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 5 DAY 22 YEAR 22		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY America		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. STATE Md					13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST John MIDDLE M. LAST (Dec)					15. MOTHER'S MAIDEN NAME FIRST Florence MIDDLE Nickens LAST (Dec)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-20-1777		17. INFORMANT ADDRESS Edward Lucas 7304 Goodland Dr. Landover Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration 5711 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to, or as a consequence of Alcoholic Hepatitis (c) Due to, or as a consequence of APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 hours 2 weeks										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/21/82 to 1/31/82, that (I) (we) last saw the deceased alive on 2/1/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael Libovich, MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Libovich, MD					22e. ADDRESS 11120 New Hampshire Ave, S.E., Md 20044					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-4-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Pr. Geo Md.			
24. FUNERAL DIRECTOR NAME George R. Snowden					24b. ADDRESS 246 N. Wash. St. Rockville, MD		25a. DATE REC'D. BY REGISTRAR FEB 9 1982			

MEDICAL CERTIFICATION

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REG. NO.

230. BURIAL  
(SPECIFY)

24 FUNERAL DIRECTOR  
NAME

John T. Rhines Co., 3015 12th St., N.E., D.C.

25a. DATE REC'D. BY REGISTRAR

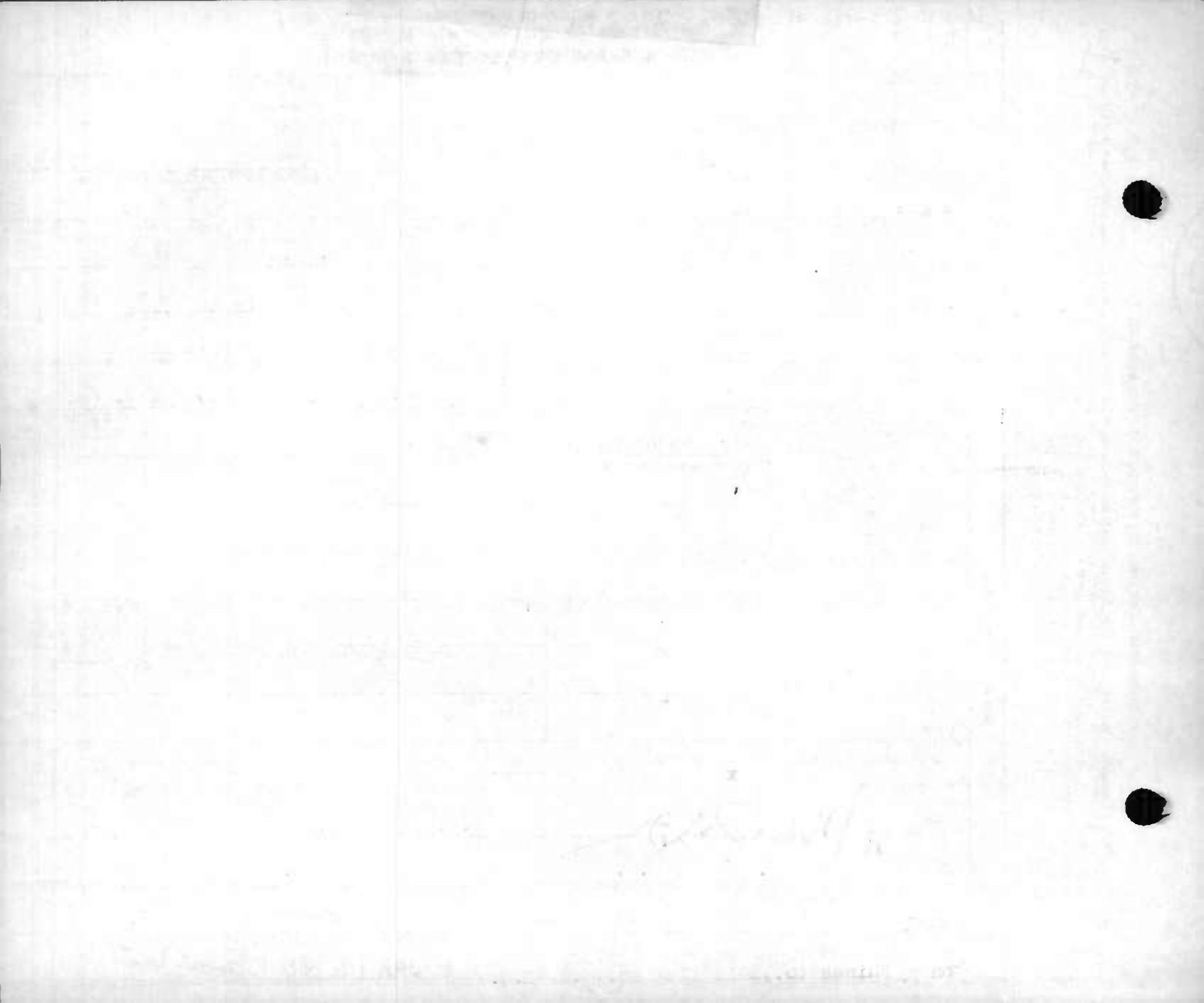
25b REGISTRAR'S SIGNATURE

JAN 18 1982

France Gall

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(VR A15 ME (5))  
15M 2/80

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 0 2 2 1 8							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES HARRISON JUND						2a. DATE OF DEATH MONTH DAY YEAR JAN 7 1982		2b. HOUR 1:45 AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR AUG 21, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) INDIANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) POTOMAC VALLEY NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST ALFRED F. HARRISON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES C. CUTCHELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-7402		17. INFORMANT ADDRESS JOHN F. JUND SAME AS 13 SON					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterio Sclerotic Heart Disease with Fibrillation acc.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a. <u>Carcinoma Breast- osteoporosis spine with Fracture</u>									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE — — — — —					
22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE 5</u> 19 <u>70</u> to <u>JAN 7</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1-7-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>P. P. Andrews</u> M.D.						DEGREE M.D.		22c. DATE SIGNED 1-7-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. P. ANDREWS						22e. ADDRESS 4977 BATTERY LA. BETHESDA MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/9/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR JAN 11 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. H. H. H.</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

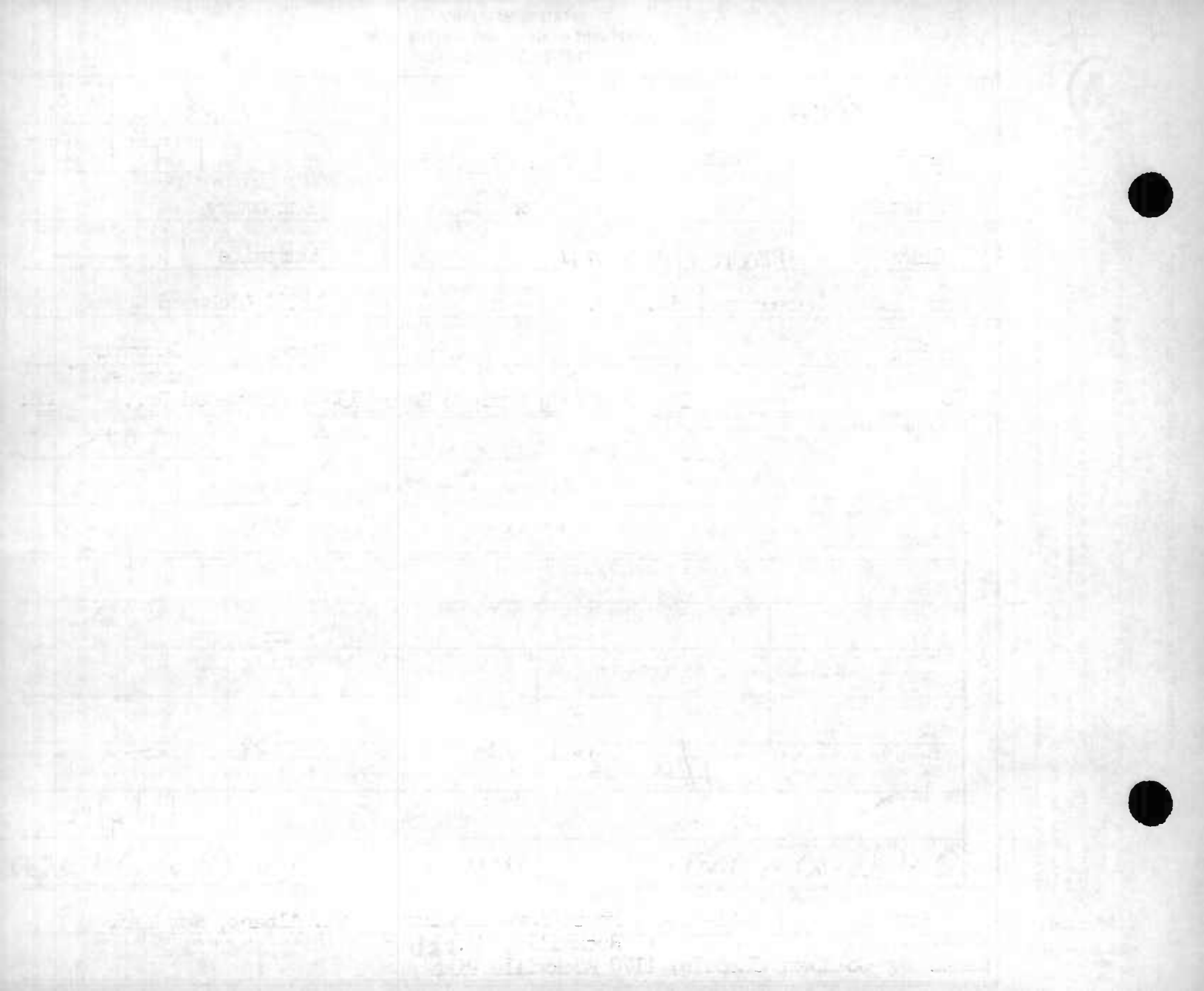
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 1 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Yetta KARO</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 82</b>		2b. HOUR <b>10 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 7, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Roumania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Beoque Grove N.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spg.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sholom Schieber</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Rachel Schwartz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>101-26-3675</b>		17. INFORMANT ADDRESS <b>Burtonsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5621 Cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Stroke and pneumonia</b> (c) <b>Schizophrenia</b>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>6 mos</b> <b>YTS</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/13</b> 19 <b>82</b> to <b>1/28</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/13</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C.H. Light</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/29/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.H. Light</b>				22e. ADDRESS <b>1811 P. Phily Dr Olney Md 20832</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-31-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montefiore Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>St. Albans, New York</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>							

MEDICAL CERTIFICATION





FOR  
1 - STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MABEL FRANCES KATZ</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 03 82</b>		2b. HOUR <b>640 P.M.</b>								
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 28, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.							
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (GIVE MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>					
13a. STATE <b>MARYLAND</b>						13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1038 Cresthaven Drive</b>	
14. FATHER'S NAME <b>GEORGE THOMAS BOARMAN</b>						15. MOTHER'S MAIDEN NAME <b>MARY LULA WATHEN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577 10 0949D</b>		17. INFORMANT ADDRESS <b>Mrs. Jeannette F. Wolin Same as #13 (Daughter)</b>									
18. CAUSE OF DEATH (Enter one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration Pneumonia</b> <b>5939</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Pulmonary Edema</b> (c) <b>Pneumothorax</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF <b>Basal Insufficiency</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/81</b> <b>12/81</b> <b>12/81</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Dehydration, ASCVD, CHF, Anemia, CAD</b>													
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>2-25-80</b> , 19____, to <b>1/3/82</b> , 19____, that (I) <del>first</del> last saw the deceased alive on <b>1/3/82</b> , 19____, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> view the body after death.													
22b. SIGNATURE <b>MBPattuck III MD</b>						DEGREE		22c. DATE SIGNED <b>1-3-82</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G B Patrick III MD</b>						22e. ADDRESS <b>9221 Cokesville Rd Silver Spring Md 20910</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/7/82</b>		23c. NAME OF CEMETERY OR CREMATOR <b>ARLINGTON NATIONAL</b>				23d. LOCATION CITY OR TOWN <b>Arlington, Arlington Va.</b>					
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Funeral Home, P.A.</b> <b>Hyattsville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. SIGNATURE <b>James J. [Signature]</b>					



UNITED STATES  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

REPORT OF  
INVESTIGATION  
ON THE  
ACTS OF  
TERRORISM

TO THE  
ATTORNEY GENERAL  
WASHINGTON, D. C.

DATE OF  
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1964

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Medical Certification by Dr. Lewis C. Lipson

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 2 2 1			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Malcolm Kaufmann</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 30 82</b>				2b. HOUR <b>5:44 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 4 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Liquor Store Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Liquors</b>					
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4701 Willard Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Malcolm Reiser</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Estelle Kaufmann</b>				ADDRESS <b>4701 Willard Ave. Chevy Chase, Md. 20815</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>579-26-8248</b>		17. INFORMANT <b>Elsa R. Kaufmann</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <b>Diabetes mellitus, Hypertension</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <b>DEC 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Lewis C. Lipson, M.D.</b>				DEGREE				22c. DATE SIGNED <b>1/30/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEWIS C. LIPSON, MD</b>				22e. ADDRESS <b>5530 WISCONSIN AVE, CHEVY CHASE, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wash. Hebrew Cong. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>							
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons</b>				5130 Wisconsin Ave. NW ADDRESS <b>Washington, D. C. 20016</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>		REGISTRAR'S SIGNATURE <b>Francis J. Nathan</b>					

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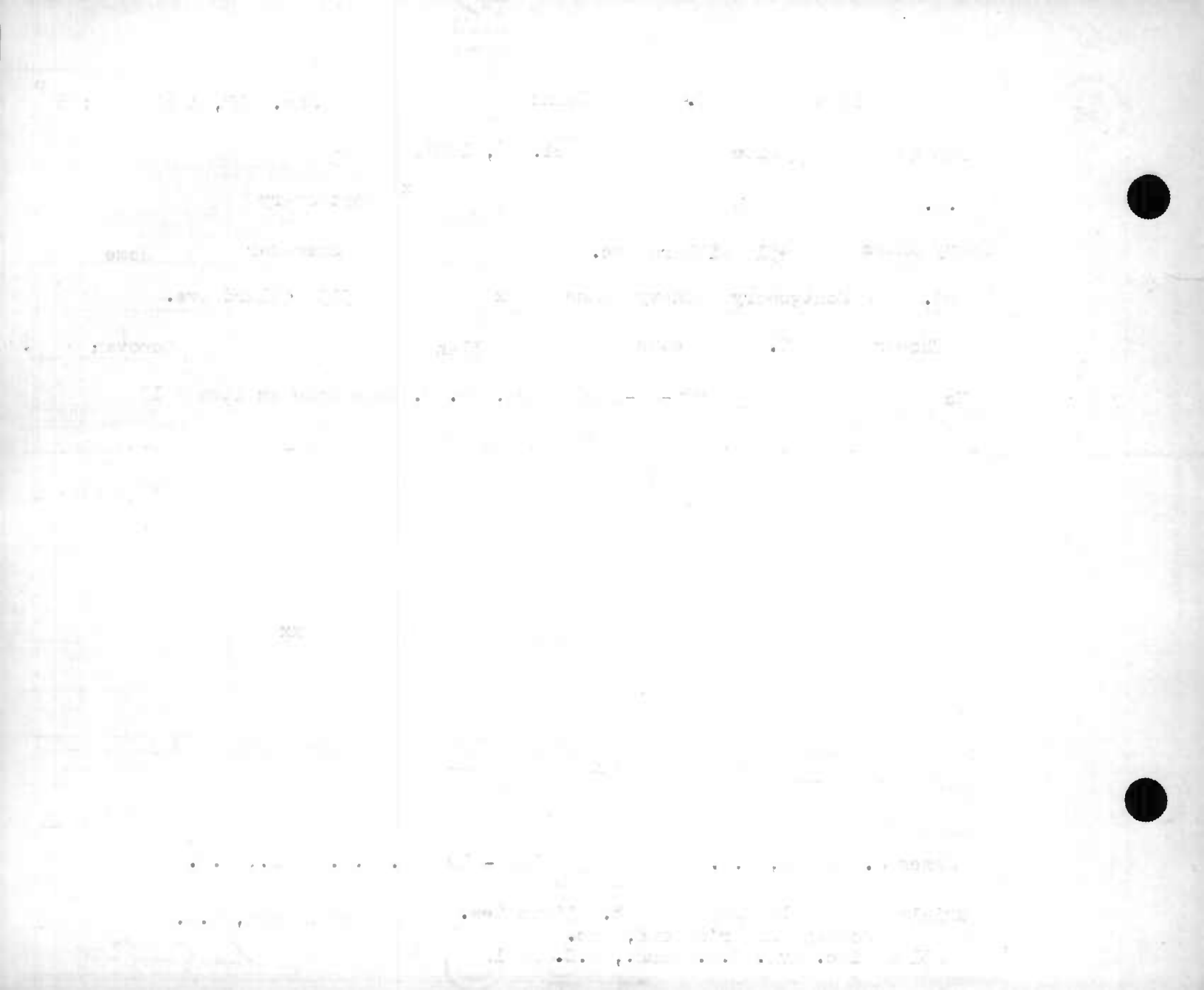
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8 2 0 2 2 2 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ellen T. Keane</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 27, 1982</b>		2b. HOUR P M <b>8:25 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 28, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4515 Willard Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD.</b>		13c. COUNTY <b>Montgomery</b>		13d. CITY OR TOWN <b>Chevy Chase</b>		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <b>4515 Willard Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas T. Keane</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen Donovan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>579-60-1606T</b>		17. INFORMANT ADDRESS <b>Mrs. Wm. C. Rose Same as item # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>JAN 27</b> 19 <b>82</b> to <b>JAN 27</b> 19 <b>82</b> that (I) (we) lost saw the deceased alive on <b>JAN 25</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James J. Foster M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James J. Foster, M.D.</b>				22e. ADDRESS <b>916 - 19th St. N.W. Wash., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Foster</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 351-2000.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 0 2 2 2 3							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Forest King, Jr.						2a. DATE OF DEATH MONTH DAY YEAR January 26, 1982		2b. HOUR 9 p.m.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 27 1917		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 500 Grandin Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Traffic	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						13e. STREET ADDRESS 500 Grandin Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Forest King, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl E. Ray					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-10-3460		17. INFORMANT ADDRESS Katherine E. King (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trachea</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/16</u> , 19 <u>71</u> , to <u>1/26</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Stephen N. Jones</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen N. Jones				22e. ADDRESS 809 Veirs Mill Road Rockville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE January 30, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				ADDRESS Funeral Homes P/A 300 W. Montgomery Ave., Rockville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 3 1982		25b. REGISTRAR'S SIGNATURE <u>Anna Jones</u>	

CHIEF OF POLICE

January 10, 1933

King, Jr.

Post

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June 27, 1933

ON

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219-10-3-10 (Post Office as 10)

to



NOTICE

Post Office as 10

Post Office as 10

Post Office as 10

Post Office as 10

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 2 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Minnie</b> <b>Pillow</b> <b>Kirks</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-5-82</b>			2b. HOUR <b>6<sup>10</sup> A.M.</b>				
3 SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JAN 5, 1890</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brooke Grove Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>WHEATON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2108 HERMITAGE AVENUE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN T. PILLOW</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY G. FERGUSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>579-12-8557</b>		17. INFORMANT ADDRESS <b>HELEN K. RICH SAME AS 13 DAUGHTER</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4290 Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>AGE 92</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 day years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Organic Brain Syndrome - Severe</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>1/2/82</b> to <b>1/5/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>C.H. Luginbuhl MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/5/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.H. Luginbuhl MD</b>			22e. ADDRESS <b>1814 P. Philip's + Olney MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/7/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PRI GEO MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS 500 UNIVERSITY BLVD., W., SILVER SPRING, MD.</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



1925-26-27

1926-27-28

1927-28-29

1928-29-30

1929-30-31

1930-31-32

1931-32-33

1932-33-34

1933-34-35

1934-35-36

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 2 5

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ST. CLAIR DAVID KIRTLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 18, 1982</b>		2b. HOUR <b>1:45PM</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 13 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER Co.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Kirtley</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNK</b>		13e. STREET ADDRESS <b>3411 Island Creek Court</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>		16b. SOCIAL SECURITY NO. <b>215 05 8592</b>		17. INFORMANT ADDRESS <b>Helen Kirtley (Wife) Same as 13E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4300 SUB ARRAHOLD HEART BR AGE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEAVY METAL HEART DISEASE. ANTICOAGULANTS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CONGESTIVE HEART FAILURE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>3 DAYS</b> <b>20 YEARS</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>MITRAL STENOSIS - HYPERTENSIVE HEART DISEASE - PROTHROMBOSIS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/14</b> , 19 <b>82</b> , to <b>1/18</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>GREGORIO KOSS</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/19/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORIO KOSS, M.D., P.A.</b>		22e. ADDRESS <b>13-15 E. Deer Park Drive Gaithersburg, Maryland 20877</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery Baltimore, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi 11800 N.H. Ave. S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>Charles J. Kirtley</b>			

101

LINEAR

101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 2 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MINNIE C KLEIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-9-82</b>				2b. HOUR <b>10-08AM</b>			
3 SEX <b>Female</b>		4 RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 27, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery-Silver Spring, MD</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mens Wear</b>			
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2800 Quebec St., N.W. #637</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Meyer Levitan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Miriam Robbin</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		(IF YES, GIVE WAR OR DATES) <b>-----</b>		16b. SOCIAL SECURITY NO. <b>577-10-7028</b>		17. INFORMANT ADDRESS <b>Joseph Klein-2313 Wash.Ave.-Chevy Chase, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 9 1975</b> , 19 <b>87</b> , to <b>Jan 9</b> , 19 <b>82</b> that (I) (we) last saw the deceased alive on <b>Jan 9 1982</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Gilbert B. Cushner</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-10-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gilbert B. Cushner</b>				22e. ADDRESS <b>11161 New Hampshire Ave.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 11, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Adas Israel Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>				25. JAN 13 1982 BY REGISTRAR <b>[Signature]</b>							
<b>1170 Rockville Pike-Rockville, Md. 20852</b>											



(M)

Blank lined paper with two binder holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 2 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JOSEPH B KNOTTS, SR.				2a. DATE OF DEATH MONTH DAY YEAR JANUARY 19, 1982				2b. HOUR 8 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 18, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MAINE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD					
10. CITY OR TOWN OF DEATH GAITHERSBURG		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GENERAL MANAGER		12b. KIND OF BUSINESS OR INDUSTRY STEEL CORP.			
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4548 N. CHARLES ST.			
14. FATHER'S NAME FIRST MIDDLE LAST LEE KNOTTS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DELLA BAKER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-9514		17. INFORMANT ADDRESS 1055 SWINKS MILL RD. JOSEPH B. KNOTTS JR. McLEAN VIRGINIA 22102							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction and Cardiac Shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Ring 1 Intubation</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>82</u> to <u>1/19</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/19</u> , 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Alberto Rotsztain</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT)				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/20/82			
22e. ADDRESS 10401 Old Georgetown Rd. Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 23, 1982		23c. NAME OF CEMETERY OR CREMATORY DULANEY VALLEY		23d. LOCATION CITY OR TOWN COUNTY STATE COCKEYSVILLE BALTO. MD.					
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25a. DATE REC'D. BY REGISTRAR JAN 27 1982		25b. REGISTRAR'S SIGNATURE <u>Frances Jean Nathan</u>					



January 19, 1962

Mr. [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

1962-0-001

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical-examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
BESSIE						KREITMAN		Jan. 19, 1982		2:50 A.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR		7b. IF UNDER 24 HRS	
Female		White		Dec. 18, 1907		74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Poland		USA				Montgomery County, MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda, Md.		Suburban Hospital						Housewife		-----	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Md.		Montgomery Potomac		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9900 Bedfordshire Court					
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Morris Majerowicz				Rachel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
NO				498-38-2633		Frances K. Feder-Daughter-Potomac, Md. 20854					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY											
IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE COLON</u>										3 YRS	
1539 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____											
DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
1979		same				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>about</u> 1936 to <u>1/19</u> 1982, that (I) (we) lost saw the deceased alive on <u>1/19</u> 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
<u>Richard H. Follen</u>		MD		1-19-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
RICHARD H. FOLLEN MD		10400 Connecticut Ave. KENSINGTON MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		1/20/82		Judean Memorial		Garden Olney - Montgomery-Maryland					
24 FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		24c. REGISTRAR'S SIGNATURE							
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		1170 Rockville Pk., Rockville, Md.		JAN 22 1982							

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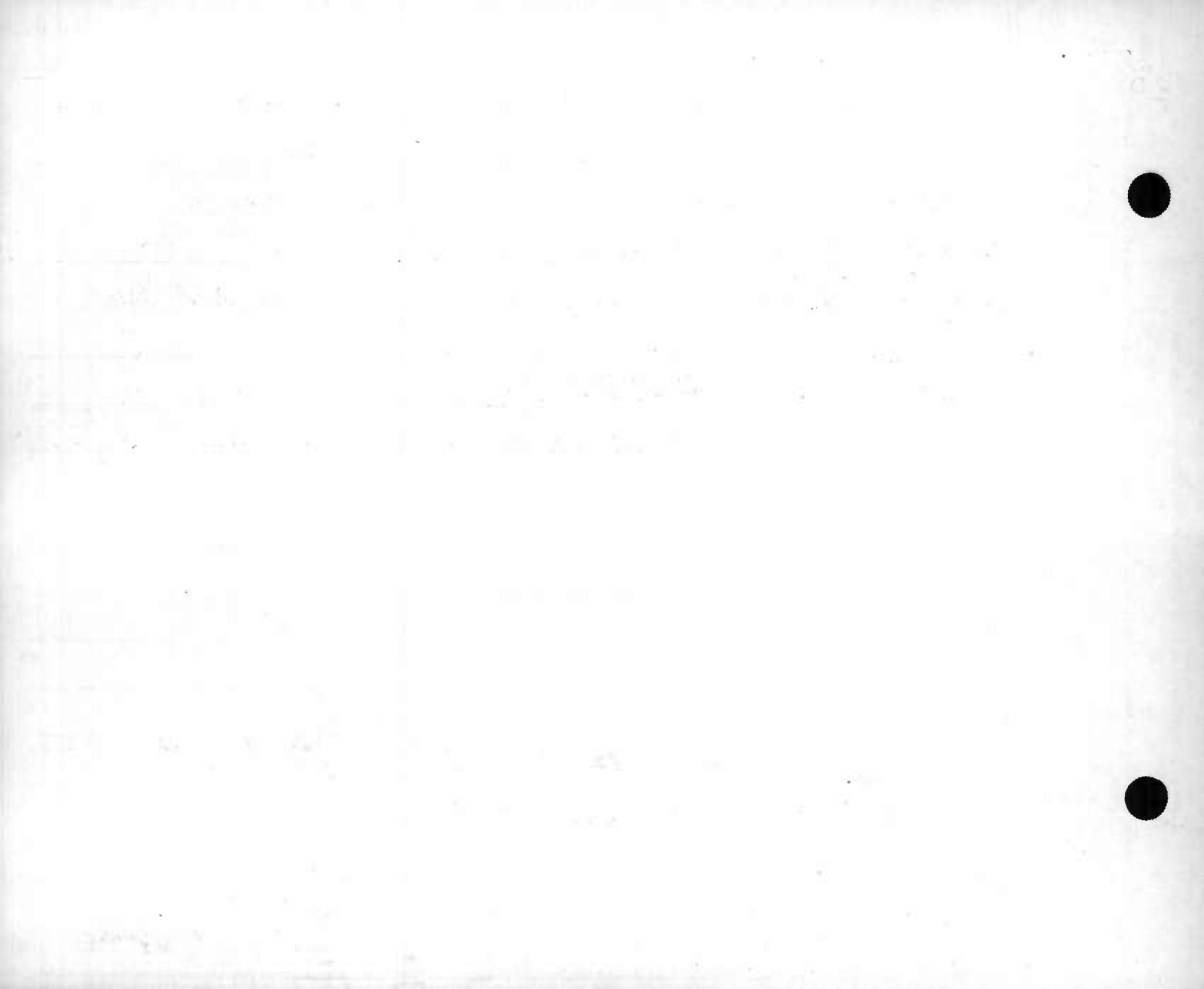
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 2 9			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada L. Larson				2a DATE OF DEATH MONTH DAY YEAR 1-9-82		2b HOUR MIN 12 4 M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 1 28 95		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 86 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Health Care Centre		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN Maryland Montgomery Silver Spring				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 3700 Marble Arch way	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM LOCKER				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NORA HTLL			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 215-48-1216		17 INFORMANT ADDRESS TARI E. LARSON SAME AS 13 HUSBAND			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 Metastatic adenocarcinoma of pancreas DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from Jan 78, to Jan 9 1982, that (I) (we) last saw the deceased alive on Jan 4 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b SIGNATURE Donald C. Dillon M.D. by Frederick Moomau				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK MOOMAU				22e ADDRESS 18111 PRINCE PHILIP DR., OLNEY, MARYLAND			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 1/12/82		23c NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a DATE REC'D. BY REGISTRAR JAN 12 1982		25b REGISTRAR'S SIGNATURE Thom...	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Raymond E. Lear</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 30 82</b>		2b. HOUR <b>12 35 P</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>December 15, 1911</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nsgng. Center</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-Employed</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Sewing Machine Repairs</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Lear</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clare Lund</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>577-07-8967</b>		17. INFORMANT <b>Florence L. Lear Wife</b>		
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma prostate</b> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-7, 1982</b> to <b>1-30, 1982</b> ; that (I) <del>lost</del> saw the deceased alive on <b>1-28, 1982</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>do</del> (did) <del>not</del> view the body after death.						
22b. SIGNATURE <b>George F. Sengstack, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-30-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George F. Sengstack, M.D.</b>		22e. ADDRESS <b>9241 Columbia Building Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis J. Collins 500 University Blvd., W. Silver Spring, Md.</b>				
25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>				

DATE

LAND OFFICE

TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Albert Gaver Leatherman			2a. DATE OF DEATH Month Day Year Jan. 2 1982			2b. HOUR 4:25 PM					
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH March 24, 1899		6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Montgomery County Md.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) National Lutheran Hm.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Pharmacist		12b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2 Ridge Road 21228					
14. FATHER'S NAME First Middle Last Addis Uriah Leatherman			15. MOTHER'S MAIDEN NAME First Middle Last Amanda Alice Gaver								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. N/A		17. INFORMANT 4404 Langtry Dr Dr. Eugene A. Leatherman		Address Glen Arm, Md. 21057				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRANSITION</u> 2639 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>obstructive vascular disease extremities</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>April 9, 1925</u> to <u>Jan 2, 1982</u> , that (I) (we) last saw the deceased alive on <u>Jan 1, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Harold F. McCann, M.D.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1-2-82				
22d. PHYSICIAN'S NAME (Type) Harold F. McCann, M.D.					22e. ADDRESS 9355-16th St N.W. WASHDC						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/5/82		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery			23d. LOCATION (City or Town) (County) (State) Woodlawn Baltimore Md.				
24. FUNERAL DIRECTOR MacNabb Funeral Home					ADDRESS Catonsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 4 1982		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C. 20535



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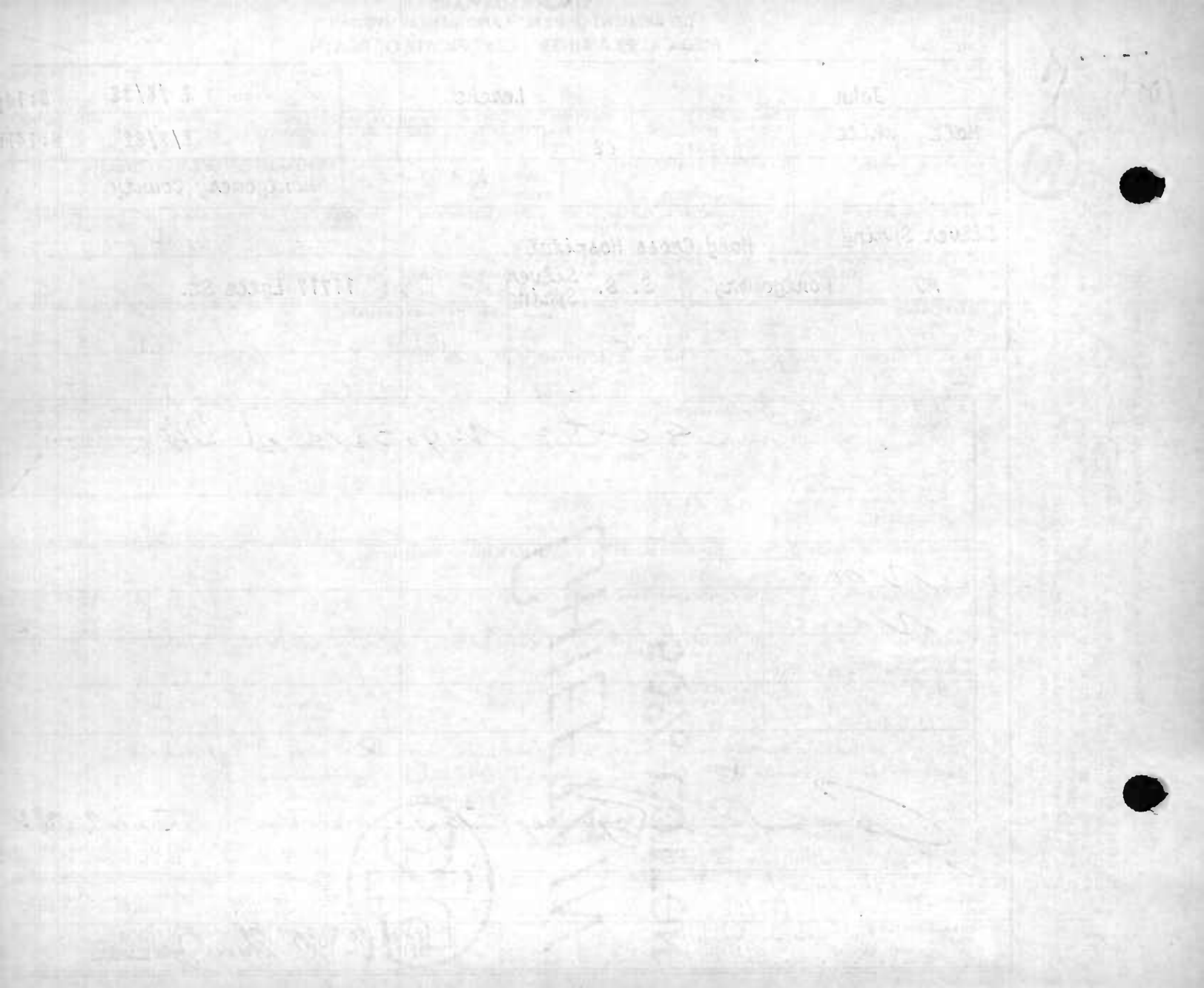
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 2 2 3 2									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					January 7, 1982					5A M				
3. SEX					4. RACE					5. DATE OF BIRTH MONTH DAY YEAR				
Male					Caucasian					Nov. 29, 1897				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YRS				
New Jersey					United States					84 YRS				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					9. BALTIMORE CITY OR COUNTY OF DEATH				
Bethesda					SUBURBAN Hosp.					Montgomery Co. MD.				
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12c. KIND OF BUSINESS OR INDUSTRY				
Maryland					Montgomery Bethesda					Attorney				
13a. STATE					13b. COUNTY					13c. CITY OR TOWN				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
George					Leonard					4949 Battery Lane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
Yes					WW I					Carol L. Gauntlett, Same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4960 Cardio-pulmonary Failure										Several hours				
Chronic Obstructive Lung Disease										Several years				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Atherosclerotic Heart Disease with Congestive Failure														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from February 1968 to 1/7 1982, that (I) (we) lost saw the deceased alive on 1/6/82 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) not view the body after death.														
22b. SIGNATURE OF ATTENDING PHYSICIAN										22c. DATE SIGNED				
Michel M. Healy M.D.										1/7/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS				
Michel M. HEALY M.D.										5652 Shields Dr Bethesda, MD 20817				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
Burial					Jan. 11, 1982					Woodlawn Mem. Park				
23d. LOCATION CITY OR TOWN COUNTY STATE					23e. DATE RECEIVED BY REGISTRAR					23f. SIGNATURE				
Easton, Maryland					JAN 12 1982					[Signature]				
24. FUNERAL DIRECTOR NAME ADDRESS														
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland														





FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 2 3 3	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John P. Lerche SR.</b>										2a. DATE KNOWN OF DEATH ESTI-MATED <input type="checkbox"/> MONTH DAY YEAR <b>1/8/82</b>					2b. HOUR <b>8:14 PM</b>						
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 25, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>1/8/82</b>		7d. HOUR <b>8:14 PM</b>									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WISCONSIN</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.									
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRESSMAN</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON POST</b>									
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>				13b. HOME CITY <b>Montgomery</b>		13c. CITY OR TOWN <b>S. S. Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>11717 Lytle St.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>HENRY LERCHE</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN HEID</b>																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>359-05-3056</b>		17. INFORMANT <b>ANNE M. LERCHE</b>				ADDRESS <b>SAME AS 13 WIFE</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>																					
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <b>John S. Rogers</b> M.D.										TITLE (SPECIFY) <b>Doc</b>				DATE SIGNED <b>Jan 9, 1982</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>										ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>											
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>				25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>							





DHMH-16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 3 4			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ERNEST J LESSENGER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 9 82</b>			
3 SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 2 20</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IOWA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NAVAL AIR INTELLIGENCE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VA</b>				13b. COUNTY <b>FAIRFAX</b>		13c. CITY OR TOWN <b>FALLS CHURCH</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ERNEST JOHN LESSENGER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE MAUDE TIBBETTS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>TO 1968</b>		17. INFORMANT ADDRESS <b>MRS. VIRGINIA LESSENGER 3701 S. GEO. MASON DR. FALLS CHURCH, VA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRAIN TUMOR</b> <b>2396</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DR.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 15</b> , 19 <b>81</b> , to <b>JANUARY 9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>JANUARY 9</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>B. Strand</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>U JAN 8</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. STRAND, LT, MC, USNR</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>January 13, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ARLINGTON, VIRGINIA</b>	
24. FUNERAL DIRECTOR NAME <b>IVES FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	
ADDRESS <b>2847 WILSON BLVD. ARLINGTON, VA</b>							



REPORT OF THE  
COMMISSIONER OF THE  
BUREAU OF THE CENSUS



and to the

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02235	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Celler			MIDDLE Levanon			LAST Levanon		
2. SEX Female		3. RACE White		4. DATE OF BIRTH MONTH DAY YEAR April 10 1929		5. AGE (IN YEARS) LAST BIRTHDAY 92 YRS.		6. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7a. DATE KNOWN OF DEATH ESTIMATED Jan 30 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH S. L. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK) Housewife					
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN S. L. Spg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS #502 E. E. Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Chiam Baderak			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Baila Latinsky								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-44-9194		17. INFORMANT Nat Levenson		ADDRESS Same as No. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dist</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Acute Respiratory Dist</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Obstruction Oropharynx by denture</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hrs	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:30 P.M. 1 29 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) N. Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Mont MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Joseph P. Rager		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER 124				DATE SIGNED Jan 30 1982			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial		23b. DATE 2/2/1982		23c. NAME OF CEMETERY Bnai Israel Congregation				23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, Pr. Geo., Maryland			
24. FUNERAL DIRECTOR NAME Donald M. Stein		ADDRESS 232 Carroll Street, N. W.		CITY Washington, D. C.		25a. DATE REC'D. BY REGISTRAR FEB 4 1982		25b. REGISTRAR'S SIGNATURE Anne J. Miller			

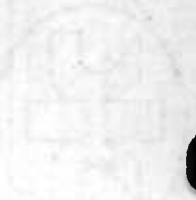


1. FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 2 3 6	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HELEN L. LIBBY				2a. DATE OF DEATH MONTH DAY YEAR 1 9 82	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 21 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. AGE (IN YEARS LAST BIRTHDAY) 94 yr. YRS MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens N. H.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Maryland		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12c. KIND OF BUSINESS OR INDUSTRY --	
13a. COUNTY Montgomery		13b. CITY OR TOWN Sil. Spr.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Winter		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 220-46-9096		17. INFORMANT Mrs. Fred Engelbrecht Sil. Spr., Md.		ADDRESS 2512 Lindell St	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio respiratory arrest terminal</u> 4409 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis 10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septic abscess lt leg.</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Septic abscess lt leg.</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1968 to 1-9-82, that (I) <input checked="" type="checkbox"/> saw the deceased alive on 1-5-82, and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE George Sengstack M.D.		22c. DATE SIGNED 1-9-82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. ADDRESS 9241 Columbia Blvd. Sil. Spr., Md.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			
23b. DATE 1/11/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc. Sil. Spr., Md.		25a. DATE REC'D. BY REGISTRAR JAN 13 1982		25b. REGISTRAR'S SIGNATURE Theresa Van Hatten	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ANNE TURNEY LIIPFERT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 7, 1982</b>				2b. HOUR <b>10:30 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 8, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Arkansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3718 Cardiff Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Turney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Perkins</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>Eugene T. Liipfert, Same address as #13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CA of breast bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b> <b>5 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>the deceased</del> died on <b>November 3, 1978</b> , to <b>January 7, 1982</b> , that (I) <del>the deceased</del> <b>was</b> <del>was</del> <b>born</b> <del>born</del> <b>on</b> <b>December 12, 1916</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>in the body after death</b> , <b>81</b>									
22b. SIGNATURE <b>Aron Primack M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-7-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Aron Primack, M.D.</b>				22e. ADDRESS <b>106 Irving St. N.W. Wash., D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James Van Winkle</b>			

John	T.	Turkey	Martha	--	Parish
10	---	508-22-735	Agents T. Abbott, same address as 17.		
Henry James Montgomery Chevy Chase		X	3718 Capital Road	Attorney	Law
Alkanan	U.S.A.	X	Montgomery		
Female	White	Dec. 8, 1936	62	Jan. 7, 1935	

RECEIVED - NOTED 3005

ORIGINAL FILED

2130 Wisconsin Ave., Washington, D.C. 20005  
 Joseph Lawler's Sons, Inc.  
 1/8/82 Cedar Hill Cemetery  
 100 Irving St. N.W., Wash., D.C.  
 Aaron Trinnick, N.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 2 3 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James W. Lincoln</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>01 25 82</b>			2b. HOUR <b>0125am</b>			
3. SEX <b>M</b>		4. RACE <b>N</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>01 23 18</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>					13b. COUNTY <b>MONTG</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAM LINCOLN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE BASIL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>					16b. SOCIAL SECURITY NO. <b>229-34-6637</b>		17. INFORMANT ADDRESS <b>Josephine Ramey - Address same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPSIS</b> <b>5719</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC Liver Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 weeks</b> <b>2 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 29</b> , 19 <b>81</b> , to <b>JAN 25</b> , 19 <b>82</b> , that (I) (we) lost the deceased alive on <b>JAN 25</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Stephen H. Hellman</b>					DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/25/82</b>		22d. ADDRESS <b>14805 PHYSICIANS ROCKVILLE, MD 20850</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>1-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montg Md.</b>		
24. FUNERAL DIRECTOR <b>George R. Snowden</b>					24b. ADDRESS <b>246 N. WASH. ST. Rockville, MD 20850</b>		24c. DATE RECD. BY REGISTRAR <b>JAN 26 1982</b>				



1. The first part of the report is a summary of the work done during the period covered by the report. It should be written in a concise and clear manner, and should not exceed one-third of the total length of the report.

2. The second part of the report is a detailed account of the work done during the period covered by the report. It should be written in a clear and concise manner, and should not exceed two-thirds of the total length of the report.

3. The third part of the report is a summary of the results of the work done during the period covered by the report. It should be written in a concise and clear manner, and should not exceed one-third of the total length of the report.

4. The fourth part of the report is a summary of the conclusions reached during the period covered by the report. It should be written in a concise and clear manner, and should not exceed one-third of the total length of the report.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

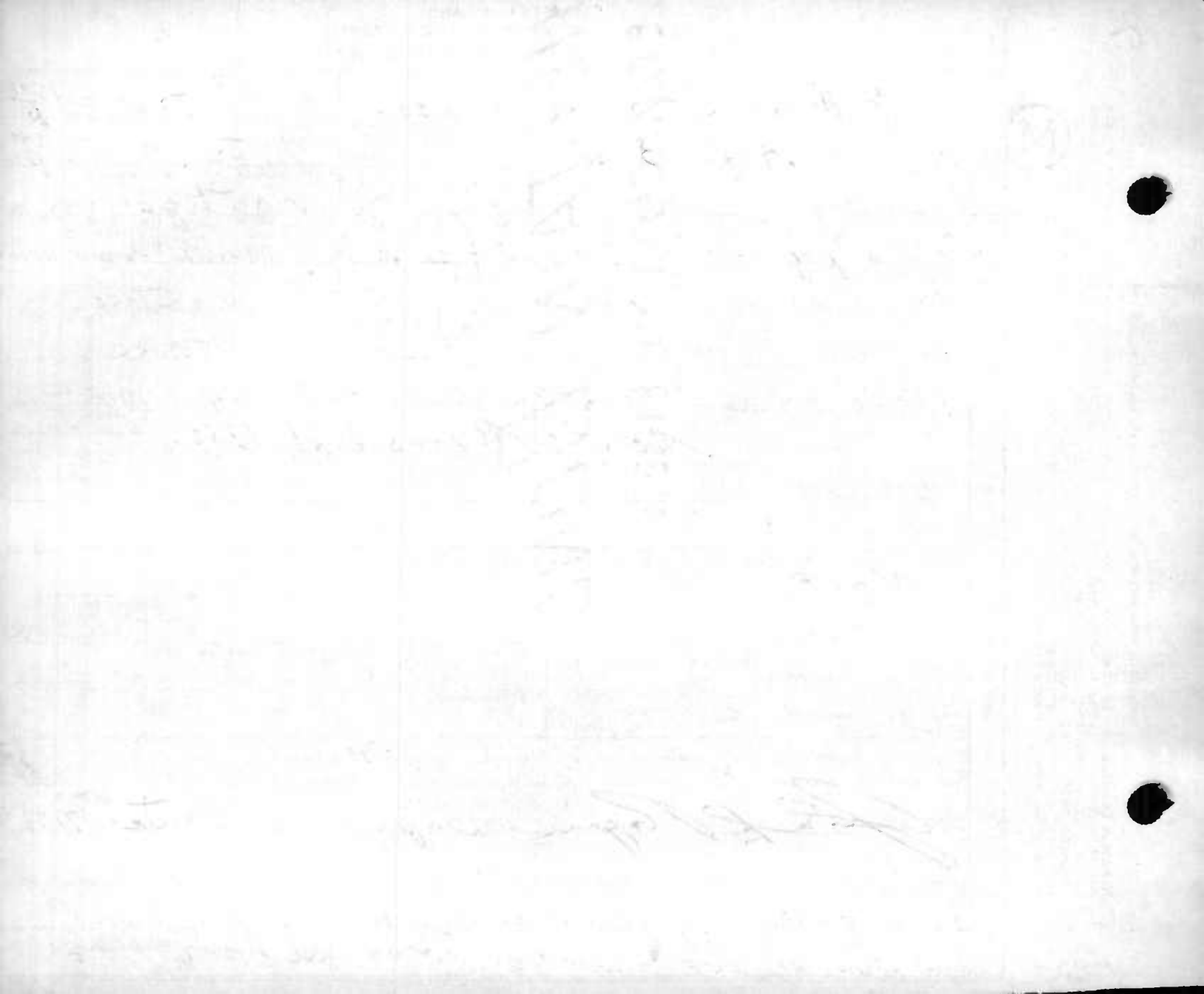
DMMH - 17  
(VR AT 15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Richard Stanley Lindsay</b>				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Jan 19 1981</b>				2b. DATE OF ESTI- MATED DEATH <input type="checkbox"/> MONTH DAY YEAR	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug 13 1913</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>68</b>		7. IF UNDER 1 YR. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bldg. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private Indus</b>	
13a. STATE <b>NONE</b>				13b. COUNTY <b>NONE</b>		13c. CITY OR TOWN <b>WASH. DC.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MICHAEL LINDSAY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EILEEN WEBSTER</b>				16. ADDRESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>577 03 6482</b>		17. INFORMANT <b>ANNE W. LINDSAY SAME # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>									
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) <b>MD.</b>				DATE SIGNED <b>Jan 19 1981</b>	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>				23b. DATE <b>JAN 21 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria VA.</b>	
24. FUNERAL DIRECTOR NAME <b>DEVL FUNERAL HOME</b>				24. ADDRESS <b>WASH. D.C.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 82 02240				
1. DECEASED NAME (TYPE OR PRINT) Hilde S. Lochner					2a. DATE OF DEATH MONTH DAY YEAR 1-6-82			2b. HOUR 12 <sup>05</sup> M	
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 1, 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) France		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONT GOMERY MD			
10. CITY OR TOWN OF DEATH SILVERSPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MD		13b. COUNTY Washington		13c. CITY OR TOWN Washington DC		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5420 Connecticut Ave. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST Christian Steinberger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Buchner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-82-5785		17. INFORMANT ADDRESS Elsbeth L. Sailer 4000 Mass. Ave. N.W. Washington, D.C. 20016					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 mins 10 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: CEREBROVASCULAR INSUFFICIENCY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from May 29, 1982, to 1/6/82 that (I) (we) last saw the deceased alive on 1/6/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Dennis J. Hand MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/6/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DENNIS J. HAND MD				22e. ADDRESS 4600 Connecticut Ave NW Washington D.C. 20008					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Removal		23b. DATE Jan. 11, 82		23c. NAME OF CEMETERY OR CREMATORY Evangelical Church		23d. LOCATION CITY OR TOWN COUNTY STATE Nierstein on Rhine, Germany			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc.				ADDRESS 5130 Wisc. Ave. Washington D.C.		25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE Renee J. Smith	



November 1, 1901

U. S. A.

France

Donation

Donation

Donation

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to

Donation

*Cleared by Medical Examiner*

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 4 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Beverly W. Loggins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 12, 1982</b>		2b. HOUR MIN. <b>2:30</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 1 1913</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>68</b>		
10. CITY OR TOWN OF DEATH <b>Derwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>18620 Muncaster Road</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Derwood</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Edmund Walker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie B. Long</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Family business</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>391-18-7665</b>		17. INFORMANT ADDRESS <b>David R. Loggins same as 13c</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>2030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) <b>Chronic obstructive pulmonary disease</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 19 77</b> to <b>12 Jan 82</b> , that (I) <del>was</del> lost saw the deceased alive on <b>6 Jan 82</b> , and that (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.						
22b. SIGNATURE <b>Donald E. Dillon</b>		DEGREE		22c. DATE SIGNED <b>12 Jan 81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Donald E. Dillon</b>		22e. ADDRESS <b>18111 Prince Phillip Drive Olney, Maryland 20832</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church Fairfax Va.</b>		23e. RECEIVED BY <b>10100 BP</b>		
1331 Rockville Pike Rockville, Maryland 20852		JAN 16 1982				

Jan. 15, 1952 2:30

Name	Address	City	State	Zip
David R. Jordan	1830 Minnesota Ave	St. Paul	MN	55105
John	1830 Minnesota Ave	St. Paul	MN	55105
Mary Ann	1830 Minnesota Ave	St. Paul	MN	55105
David R. Jordan	1830 Minnesota Ave	St. Paul	MN	55105

David R. Jordan  
1830 Minnesota Ave  
St. Paul, MN 55105  
1/15/82  
1830 Minnesota Ave  
St. Paul, MN 55105

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 4 2			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME FIRST MIDDLE LAST <b>RUSSELL LINCOLN LORENTSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 15, 1982</b>		2b. HOUR <b>3:33 a.m.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 12, 1931</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>A.A. Co. School Brd.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ANNE ARUNDEL</b>		13c. CITY OR TOWN <b>PASADENA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES I. Lorentson Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNA CHRISTIANSON</b>		13e. STREET ADDRESS <b>718 214th STREET PASADENA, MARYLAND 21122</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>Vietnam &amp; Korea 136-24-5574</b>		17 INFORMANT (Wife) <b>DORIS E. LORENTSON: PASADENA, MD 21122</b>		17b. STREET ADDRESS <b>718 214th STREET</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION WITH RUPTURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>09 JANUARY 82</b> to <b>15 JANUARY 82</b> , that (I) (we) lost saw the deceased alive on <b>15 JANUARY 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles Chang</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. CHANG, LCDR, MC, USN</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>18 Jan. 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MD. State Vet. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, A.A. MD.</b>	
24 FUNERAL DIRECTOR NAME <b>Singleton Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James S. Smith</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 2 0 2 2 4 3	
1- STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Herman Henry Luebbing</b>										2a. DATE KNOWN OF DEATH <b>Jan 14 1982</b>	
3. SEX <b>M</b> 4. RACE <b>W</b> 5. DATE OF BIRTH <b>May 14 1930</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS. 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>										2b. DATE OF DEATH <b>Jan 14 1982</b>	
10. CITY OR TOWN OF DEATH <b>Sil. Spg</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1003 St Vont St</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TECH. DENTAL</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>NAVAL HOSPITAL</b>										2c. DATE PRONOUNCED DEAD <b>Jan 14 1982</b>	
13a. STATE <b>MD</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>Sil. Spg</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>1003 St Vont St</b>											
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>HERMAN H. LUEBBING</b> 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>PERSIS D. DIGGS</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b> 16b. SOCIAL SECURITY NO. <b>219-34-7899</b> 17. INFORMANT <b>ELIZABETH M. LUEBBING</b> ADDRESS <b>SAME AS 13 WIFE</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Polycystic Kidney</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 7581										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>51 Yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR _____ P.M. 19 _____ 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) _____											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>Wep</b> MEDICAL EXAMINER TITLE (SPECIFY) _____ DATE SIGNED <b>Jan 14 1982</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b> ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b> 23b. DATE <b>1/19/82</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Memory Gardens Mem Ph</b> 23d. LOCATION CITY OR TOWN <b>Lake Worth</b> COUNTY <b>Palm Beach</b> STATE <b>Fla</b>											
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b> 25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James Jan Thorton</b>											

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THEODORE J. LUND			2a. DATE OF DEATH MONTH DAY YEAR 1 - 25 - 82			2b. HOUR 6:40 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Barnett Lund				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II			17. INFORMANT ADDRESS Pearl Lund; 509 Quaint Acres Dr., SSpg., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant melanoma 1729 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/5, 1982, to 1/25, 1982, that (I) (we) last saw the deceased alive on 1/25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE 1/26/82 MD KIRKLAND C. BRACE						22c. DATE SIGNED 1/26/82		22d. ADDRESS 1600 CARROLL AVE, TAKOMA PARK, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-27-1982		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden Rockville, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia		
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



FIELD NO. 100-8006

EXC. M. 1711



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Annie Belle Luper</b>			2a. DATE OF DEATH MONTH <b>01</b> DAY <b>09</b> YEAR <b>82</b>		2b. HOUR <b>0105<sup>PM</sup></b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>03</b> DAY <b>31</b> YEAR <b>19</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>retired school bus driver</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>md.</b> 13b. COUNTY <b>mont.</b> 13c. CITY OR TOWN <b>Rockville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>M.</b> LAST <b>Morris</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Neta</b> MIDDLE <b>Winborne</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>243-16-5120</b>		17. INFORMANT ADDRESS <b>Paul J. Luper same as 13c</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30min</b> <b>10yr.</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/1/82</b> to <b>1/9/82</b> , that (I) (we) lost <b>1/1/82</b> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated.					
22b. SIGNATURE <b>Robert C. Macon</b> M.D.				22c. DATE SIGNED <b>1/9/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert C. Macon / John S. Soia</b>				22e. ADDRESS <b>809 Viens Mill Rd., Rockville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>	
23d. LOCATION CITY OR TOWN <b>Rockville, Maryland</b>		23e. STATE <b>Md</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Md. 20852</b>					



North Carolina USA  
 Montgomery  
 retired school bus driver

George H. Morris  
 247-15-7120 Paul J. Inger name as 15e  
 no --



Burial 1/15/02  
 Tyron Wheeler Funeral Home, Inc.  
 1331 Hookville Rd. Hookville, Md. 20822  
 Parkview Memorial Park - Hookville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>BERNARD S. LUST</b>				2a. DATE OF DEATH <b>January 19, 1982</b>		2b. HOUR <b>7:32pM</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JULY 4, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY COUNTY GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MOVIE THEATRES</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS <b>18349 DUTCHESS DRIVE</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>OLNEY</b>		13d. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>	
14. FATHER'S NAME <b>SIDNEY LUST</b>				15. MOTHER'S MAIDEN NAME <b>CELIA COOPERMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>578-16-0767</b>		17. INFORMANT <b>900 HENRY STREET, WEST SAM B. LUST, LINDEN, NEW JERSEY 07036</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Sudden death</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>End stage renal disease; fractured ribs secondary to fall 1 week prior</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>acc</b> , 19 <b>79</b> , to <b>1-19-82</b> , 19 _____, that (I) (we) lost saw the deceased alive on <b>1-18-82</b> , 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Peter Berkman M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. PETER BERKMAN, M. D.</b>				22e. ADDRESS <b>106 IRVING STREET, N. W. WASHINGTON, D. C.</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b. DATE <b>1/22/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>OLNEY, MONTGOMERY, MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>EDWARD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>			
24. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>				25b. REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 03-11-2011 BY 60322

COLLECTION

OVERVIEW





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 4 7 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Nellie (none) Lynch</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>01 05 82</b>				2b. HOUR <b>9:30P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 04 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Bethesda, Montgomery MD.</b>							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Retirement Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Private Indust</b>				
13a. STATE <b>DC</b>					13b. COUNTY <b>MD</b>		13c. CITY OR TOWN <b>Wash. D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>4801 Conn. Ave., N.W.,</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Martin Lynch</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Casey</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>578-01-2154</b>		17. INFORMANT ADDRESS <b>Brother-Robert E. Lynch- Same as #9</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gastrointestinal Bleeding</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b> <b>8 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION -----			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -----				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. -- 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) -----							
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -----			21f. LOCATION STREET -- CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>May 12-16- 19 82</b> to <b>1/5/ 19 82</b> , that (I) (we) lost saw the deceased alive on <b>12-16- 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Dennis J. Hand</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>1/6/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dennis J. Hand</b>					22e. ADDRESS <b>4600 Conn. Ave., N.W., Wash., D.C. 20008</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 8, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>Robert A. DeVol</b> ADDRESS <b>DeVol Funeral Home</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1982</b>			25b. REGISTRAR'S SIGNATURE <b>James Van Natta</b>					
26. FUNERAL HOME NAME <b>2222 Wisc. Ave., N.W., Wash. D.C.</b>													

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 0 2 2 4 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Amy Cloud Lynn										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR Jan 2, 1982	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7b. HOUR 8:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		7c. DATE PRONOUNCED DEAD Jan 2, 1982	
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 136 Duval Lane Apt. T-3				17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Analyst		7d. HOUR 9:15 AM	
13a. STATE Maryland				13b. CITY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
14. FATHER'S NAME FIRST MIDDLE LAST George Fountain Peters						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude A. Treavey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-03-4462		17. INFORMANT ADDRESS Mr. Newman P. Lynn, Son, Same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) Deputy				DATE SIGNED Jan. 2, 1982			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				ADDRESS 7936 Old Georgetown Road Bethesda, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Potomac Methodist Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac Montgomery MD.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. K...</u>			

Cardio Vascular Disease

John A. Noel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8202249							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Evelyn G. Marshall</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1/6/82</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7b. HOUR <b>3<sup>45</sup> AM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>National Road Fed.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8409 Old Georgetown Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris Peabody</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace N. Head</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-36-8105</b>		17. INFORMANT ADDRESS <b>William E. Marshall Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe brain damage</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF <b>Cardiac arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>8 days</b> <b>many years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.0 <b>Diabetes Mellitus +</b>									
19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>none</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 5 1982</b> to <b>Jan 5 1982</b> , that (I) (we) saw the deceased alive on <b>Jan 5 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Allen J. O'Neill</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <b>Jan 6, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen J. O'Neill</b>				22e. ADDRESS <b>Bethesda, Md. 8601 Old Georgetown Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>January 9, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b> 25b. REGISTRAR'S SIGNATURE <b>James J. Matthews</b>					

SECRET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 5 0			
1. DECEASED NAME (TYPE OR PRINT) <b>Miller Wood Life MARSHALL</b>				2a. DATE OF DEATH MONTH DAY YEAR 1-27-82			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN 19, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>MTA Inc</b>		13c. STREET ADDRESS <b>26625 Mullinix Mill Rd</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Miller N/A Woodlife</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann N/A Parks</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>578-18-9481</b>		17. INFORMANT ADDRESS <b>Ruth Marshall see 13E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>multiple myeloma</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>RENAL FAILURE</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>November 24, 1981</b> , to <b>January 27, 1982</b> , that (1) <del>was</del> last saw the deceased alive on <b>January 26, 1982</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> did not view the body after death.							
22b. SIGNATURE <b>Barry Hecks</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/27/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY HECKS</b>				22e. ADDRESS <b>3929 FERRARA DRIVE WHEATON, MD 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>JAN 27, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md</b>	
24. FUNERAL DIRECTOR NAME <b>W. J. Chambers</b> ADDRESS <b>8605 Georgia Ave S.S. Md</b>				25a. FILE NO. BY REG. CLERK <b>1982</b> 25b. BY REGISTRAR <b>1982</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <i>Maudie Malone Martin</i>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <i>1-4-82 9<sup>42</sup> P M</i>				
3 SEX <i>Female.</i>		4. RACE <i>Asiatic. Guyana D</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Mar. 3, 1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Guyana.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA Perm. Res.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Takoma Park.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>House Wife.</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland.</i>		13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Takoma Park</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Not Known. Stanley</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Not Known.</i>				13e. STREET ADDRESS <i>Takoma Park, Md. 2213 Roanoke Ave.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>052-46-2399</i>		17. INFORMANT ADDRESS <i>Maxene Tait. Daughter 13 e</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CANCER OF PANCREAS</i> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>12.2 1981</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>9013 FLOWER AVE SILVER SPRING MD 20901</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1-4-82</i> to <i>1-4-82</i> that (I) (we) last saw the deceased alive on <i>1-4-82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>M Snow MD</i>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>1-5-82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M SNOW M.D.</i>					22e. ADDRESS <i>9013 FLOWER AVE SILVER SPRING MD 20901</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial.</i>		23b. DATE <i>Jan. 7, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Ame Zion</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Odenton, Md.</i>		
24. FUNERAL DIRECTOR (NAME) <i>Arthur Kellers</i>					25a. DATE REC'D. BY REGISTRAR <i>JAN 11 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>		

MEDICAL CERTIFICATION

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Wynne.  
Horn. Hen.  
Lovera  
Alistic.

HOONOR-TH.  
No. 3, 1901

Wynne.  
Horn. Hen.  
Lovera  
Alistic.

No. 3, 1901



Wynne.  
Horn. Hen.  
Lovera  
Alistic.

No. 3, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Jean M. MARYAK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1/24/82</b>		2b. HOUR <b>12<sup>20</sup> AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1940</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Microbiologist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N.I.H.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13e. STREET ADDRESS <b>13409 Valley Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>J. Scott MacIennan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Iva C. Ellis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>146 32 9003</b>		17. INFORMANT ADDRESS <b>John L. Maryak Same as item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>EXSANGUINATION</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS.</b>
5714 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>PERFORATED SMALL BOWEL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CHRONIC ACTIVE HEPATITIS AND CHRONIC STEROIDS</b>							<b>3 WKS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>LIVER FAILURE S/P SMALL BOWEL INFARCTION 2° TO VENOUS THROMBOSIS</b>							<b>10 YRS</b>
19a. DATE OF OPERATION <b>1/23/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED SMALL BOWEL</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>DEC</b> , 19 <b>81</b> , to <b>JAN 23</b> , 19 <b>82</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>JAN 23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E.D. Hanowell</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/25/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>E.D. HANOWELL, MD</b>				22e. ADDRESS <b>10401 OLD GEORGETOWN RD BETHESDA</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 26, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>				25. DATE RECEIVED BY REGISTRAR <b>FEB 1 1982</b> REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

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EXAMINATION

PREPARED BY: [illegible]

CHINESE FIVE LETTERS AND CHINESE SPEECH

AND FIVE LETTERS IN CHINESE SPEECH

PREPARED BY: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the health officer within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTIN A MASON					2a. DATE OF DEATH MONTH DAY YEAR 1 12 82			2b. HOUR 11:07P	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 23 07		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer Prof.		12b. KIND OF BUSINESS OR 1060 Geo. Wash- ington Univ.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3621 Raymond St.	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander Mason					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Arenz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 79-32-0192		17. INFORMANT ADDRESS Winnifred M. Mason Same as 13					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hypertension</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/5</u> , 19 <u>81</u> , to <u>1/11</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1/11</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr Joseph Kenrick</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr JOSEPH KENRICK</u>				22e. ADDRESS <u>6450 Wisconsin Ave Bethesda, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE January 16 1982		23c. NAME OF CEMETERY OR CREMATORY Pohick Ep. Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lorton, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 21 1982 <u>James San Nathan</u>					

15. *Phragmites australis* (Cav.) Trin. ex Steud.



## CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Ashton T. Mathurin			2a. DATE OF DEATH MONTH DAY YEAR Jan. 1, 1982			2b. HOUR M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 11- 9- 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Panama		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4506 Falcon Ct.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Refrigeration Eng		12b. KIND OF BUSINESS OR INDUSTRY Shipping	
13a. STATE Maryland		13b. COUNTY Mont.		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Peter Mathurin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fernand UNKNOWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 061-24-6523		17. INFORMANT ADDRESS Alline E. Mathurin 4506 Falcon Ct. Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Adenocarcinoma to liver</u> 1991 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/11/81</u> to <u>12/29</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>12/29</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Michael Leibowitz</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4 Jan 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz		22e. ADDRESS 1120 New Hampshire Ave Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-6-82		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.	
24. FUNERAL DIRECTOR NAME Barnes & Matthews, Inc.		ADDRESS 3619 14th St., N.W. D.C.		25a. DATE REC'D. BY REGISTRAR JAN 7 1982			
25b. REGISTRAR'S SIGNATURE John Mathurin							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607

(23)

THE UNIVERSITY OF CHICAGO  
LIBRARY  
1000 S. MICHIGAN AVE.  
CHICAGO, ILL. 60607

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

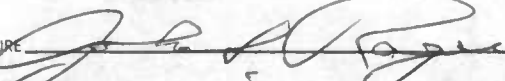

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		JENNIE Emily Mattera		1-21-82 <sub>9</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	12:30
female	white	July 11, 1916	65 YRS.	MONTHS DAYS HOURS MIN		1-21-82 <sub>19</sub>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
New Jersey	United States				Montgomery County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS INDUSTRY	
Bethesda	4501 Traymore Street			Took and Die Machinist		Machinist Ship	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. CITY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Bethesda	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4501 Traymore Street			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
John Skolnik		Katherine Karp					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		158-16-0908		Mr. Albert A. Mattera, Husband Same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED			
Margarita A. Korell, M.D.		M.D. Assistant		1-22-82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation	Jan. 24, 1982	Metropolitan Crematory, Alexandria, Virginia		CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		JAN 27 1982		Frances Santhorne			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 6 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 2 5 6		
1. DECEASED NAME (TYPE OR PRINT) <b>Niels John Matthiesen</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1/5 1982</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1/5 1982</b>		7b. HOUR <b>10:25 A.M.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sweden</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9940 Cottrell Terrace</b>						12a. USUAL OCCUPATION (TYPE OF WORK) <b>TV Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9940 Cottrell Terrace</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>M. J. Matthiesen</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie N. Nielsen</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>						16b. SOCIAL SECURITY NO. <b>070-14-7300</b>		17. INFORMANT <b>Reva L. Fuschino</b> <b>13613 Stepmey Lane, Chantilly, Va. 22021</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>												
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER		DATE SIGNED <b>1/5/82</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road, Silver Spring, Montgomery, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>				23b. DATE <b>1-8-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Walton Cemetery</b>			23d. LOCATION <b>Walton Delaware</b> COUNTY <b>N. Y.</b> STATE			
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE 				

1. The first

2. The second

3. The third

4. The fourth

5. The fifth

6. The sixth

7. The seventh

8. The eighth

9. The ninth

10. The tenth

11. The eleventh

12. The twelfth

13. The thirteenth

14. The fourteenth

15. The fifteenth

16. The sixteenth

17. The seventeenth

18. The eighteenth

19. The nineteenth

20. The twentieth

21. The twenty-first

22. The twenty-second

23. The twenty-third

24. The twenty-fourth

25. The twenty-fifth

26. The twenty-sixth

27. The twenty-seventh

28. The twenty-eighth

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 5 7			
1. FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>Barbara Prier McAdoo</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 26, 1982</b>		2b. HOUR <b>7:10</b> a. M	
3 SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 3, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>613 Goldsborough Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>613 Goldsborough Drive</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond A. Prier</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jane Lewis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>Richard F. McAdoo same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of the Pancreas</b> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>2/9</b> , 19 <b>81</b> , to <b>1/26</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>12/11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) <b>Stephen J. Newman</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/26/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen J. Newman</b>				22e. ADDRESS <b>5411 W. Cedar Lane Bethesda, Md. 20014</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/29/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>				24b. ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>			

JAN 26 1982

1551 Rockville Pike Rockville, Maryland

Tyner Wheeler Funeral Home, Inc.

Bureau

1/29/65

Stephen G. Newman

5412 N. Green Lane Bethesda, Md. 20814

no

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21-11-65 Richard F. McAdoo came in 196

Raymond A.

Prater

Jane

Lewis

Mariland

Montgomery

Rockville

x

613 Goldsborough Drive

Rockville

613 Goldsborough Drive

Rockville

home

California

USA

Montgomery

Texas

white

Dec. 5, 1964

57

McAdoo

Prater

Barbara

Jan. 20, 1965 7:10



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 . 0 2 2 5 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	
MARGUERITE A McALEER				01 07 82	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 01 16 97	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 84 RS. 84	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES BLESSING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET E. WAGNER		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-03-9756		17. INFORMANT SON JOHN H. McALEER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 Respiratory arrest		DUE TO, OR AS A CONSEQUENCE OF (b) Sudden massive CVA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral embolus		4 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: A SHD - Multiple embolic phenomena - A-V disconnection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/7/82 to 1/7/82 that (I) (we) last saw the deceased alive on 1/7/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard P. Delaney MD		DEGREE		22c. DATE SIGNED 1-7-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DELANEY MD		22e. ADDRESS 4323 HAVARD ST. SILVER SP. 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/11/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		JAN 11 1982		Francis J. Collins	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 2 6 0					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH						MONTH		DAY		YEAR		2b. HOUR	
JOHN P. McCalister		January						4		1982		2:35 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		May 26, 1895				86				YRS.		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.			
Indiana		U.S.A.						Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR					
Silver Springs		Holy Cross Hospital				Pattern Maker				General Motors Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8505 Springvale Road							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Charles F. McCalister		Unknown													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT											
Yes		WW I		305 01 9955				Carolyn Rander							
								6464 Fairborn Terrace New Carrollton, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Renal Failure</u>												2 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												10 years			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Alcoholism Disease</u>															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Vasculitis</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION											
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>				STREET		CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from <u>16 Jan 1982</u> to <u>4 Jan 1982</u> , that (1) (we) lost saw the deceased alive on <u>16 Jan 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE				22c. DATE SIGNED									
<u>Michael Leibowitz</u>						4 Jan 1982									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
Michael Leibowitz		1120 New Hampshire Ave													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Burial		1/6/82		Washington Park Cemetery		Indianapolis, Indiana									
24. FUNERAL DIRECTOR						25a. DATE FILED BY REGISTRAR		25b. SIGNATURE							
Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland						JAN 7 1982									

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No.

Date

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 6 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	MIN
JOHN WILLIAM McINNES					JANUARY 9, 1982				11:33	AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	JULY 24, 1914		67		MONTHS		DAYS		HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
ARKANSAS	U.S.A.			MONTGOMERY						MD.
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
OLNEY	MONTGOMERY GENERAL HOSPITAL		Mechanic		Heavy Equip.					
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS					
MARYLAND		MONTG.	WASH. GROVE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	215 Laytonsville Rd. BOX 344					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
ROBERT - McInnes		EDNA - DAVIS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Yes		WWII		431-10-9889		Mable I. McInnes		Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> <u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>CHRONIC CONGESTIVE HEART FAILURE AND CORONARY INSUFFICIENCY 15 YEARS</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45'</u> <u>LESS THAN 12 HRS</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> <u>ESOPHAGEAL STRICTURE FROM REFLUX.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
Jan - 7 - 82		PEPTIC Esophagitis & STRICTURE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan - DEC - 12 - 19 81</u> to <u>Jan 9 - 82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan - 9 - 82</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Mario Diaz</u> DEGREE		22c. DATE SIGNED <u>Jan - 9 - 82</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
MARIO DIAZ, M.D.		18111 Prince Philip Drive Olney, Maryland 20832								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
BURIAL		Jan. 12, 1982		Parklawn		Rockville Mont. Md. STATE				
24. FUNERAL DIRECTOR NAME		ADDRESS		DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE				
FRANCIS H. BARBER		LAYTONSVILLE, MD. 20879		JAN 13 1982						

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EXAMINER MUST BE NOTIFIED OF ONCE.

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

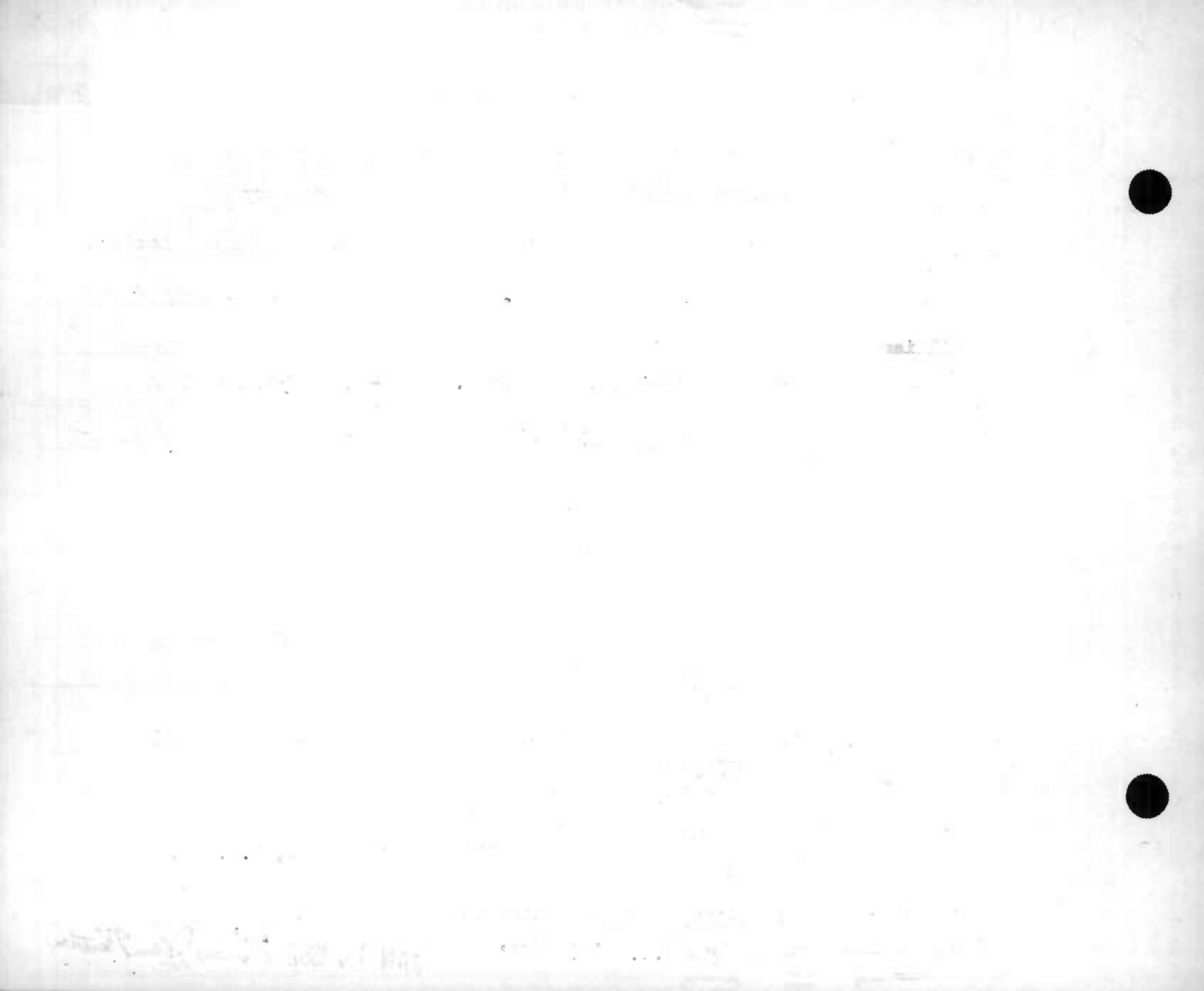
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 6 2

1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DAVID F MCKAY SR		2a. DATE OF DEATH MONTH DAY YEAR 1 10 82	
3 SEX MALE		7b. HOUR 730 P M	
4 RACE WHITE		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR 4 20 18		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SCOTLAND		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
7b. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER	
10. CITY OR TOWN OF DEATH SILVER SPRINGS		12b. KIND OF BUSINESS OR INDUSTRY Retired	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BEL PRE HEALTH CARE CENTER		13a. STREET ADDRESS 4011 HEATHFIELD RD	
13a. STATE MD		13b. CITY OR TOWN Rock.	
14 FATHER'S NAME FIRST MIDDLE LAST William McKay		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Foggo	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 218-38-9149	
17 INFORMANT Mary C. McKay-wife- (same as 13e)		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell cancer of lung</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-81</u> 19 <u>81</u> , to <u>1-10-82</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1-10-82</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>Morris Perry</u>		22c. DATE SIGNED 1/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MORRIS PERRY		22e. ADDRESS 11602 Georgia Ave., S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1-12-1982	
23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, DC	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		25a. DATE REC'D. BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) JAN 14 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 6 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED A. MCNIFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 14 1982</b>			2b. HOUR A. <b>2:20 M</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 14 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>IF UNDER 24 HRS HOURS MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>19315 Club House Rd. - Apt. 203</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael J. Ryan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah - McMahon</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>169-22-8679</b>			17. INFORMANT <b>Gerard L. McNiff</b>			18. ADDRESS <b>19315 Club House Rd. #203 Gaithersburg, Md. 20879</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ISCHEMIC CARDIOMYOPATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 MONTHS</b> <b>15 MONTHS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>NOV 19 81</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>11125 ROCKVILLE PIKE, ROCKVILLE, MD</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 13 19 82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>ROGER STEVENSON, JR</b>			22c. DEGREE <b>MD</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>1/14/82</b>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER STEVENSON, JR</b>			22g. ADDRESS <b>11125 ROCKVILLE PIKE, ROCKVILLE, MD</b>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			
23b. DATE <b>1/18/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat. Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Arling Va.</b>			
24. FUNERAL DIRECTOR <b>Gartner Sandison F.H.</b>			25. ADDRESS <b>316 E. Diamond Ave. Gaithersburg, Md. 20877</b>			26. DATE OF REGISTRATION <b>JAN 18 1982</b>			

24. FUNERAL DIRECTOR

316 E. Diamond Ave.

JAN 18 1982

Gartner Sandison F.H.

NOTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MIDDLE LAST <b>TRACY HANEY McQUOWN</b>					MONTH DAY YEAR <b>1-11-82</b>				
3. SEX					2b. HOUR				
4. RACE					6. AGE (IN YEARS LAST BIRTHDAY)				
5. DATE OF BIRTH					IF UNDER 1 YEAR IF UNDER 24 HRS				
FEMALE					MONTHS DAYS HOURS MIN.				
CAUCASIAN					74 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9. BALTIMORE CITY OR COUNTY OF DEATH				
PENNSYLVANIA					MONTGOMERY COUNTY MD.				
7b. CITIZEN OF WHAT COUNTRY?					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
U.S.A.					SECRETARY OFFICE OF DEFENSE				
10. CITY OR TOWN OF DEATH					12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA					SUBURBAN HOSPITAL				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					13a. STREET ADDRESS				
12c. INSIDE CITY LIMITS?					13b. COUNTY				
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					MONTGOMERY				
13c. CITY OR TOWN					14. FATHER'S NAME				
SILVER SPRING					FIRST MIDDLE LAST				
15. MOTHER'S MAIDEN NAME					FIRST MIDDLE LAST				
ANNA M. SMITH					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				
16b. SOCIAL SECURITY NO.					17. INFORMANT				
218-38-8311					SON				
THOMAS H. McQUOWN					WOODBRIDGE, V. 22192				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).									
PART 1: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <b>Metastatic oat cell carcinoma</b>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <b>Primary - lung</b>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
19c. AUTOPSY?									
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION									
STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 19 <b>64</b> to <b>1-11</b> 19 <b>82</b> , that (I/we) last saw the deceased alive on <b>1-10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE									
DEGREE									
MD									
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED									
1-11-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
DL Bucy / S N Jones									
22e. ADDRESS									
80 queens mill Rd Rockville									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
BURIAL									
23b. DATE									
1/14/82									
23c. NAME OF CEMETERY OR CREMATORY									
PARKLAWN CEMETERY									
23d. LOCATION									
CITY OR TOWN COUNTY STATE									
ROCKVILLE MONT MD.									
24. FUNERAL DIRECTOR									
NAME									
FRANCIS J. COLLINS									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									
25a. DATE REC'D. BY REGISTRAR									
JAN 18 1982									
25b. REGISTRAR'S SIGNATURE									
Name Jan 18 1982									

MEDICAL CERTIFICATION

3901 BP





BP

DHMH - 16.50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8202265	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Rose Meredith						2a. DATE OF DEATH MONTH DAY YEAR 1-8-82		2b. HOUR 7:10 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-16-1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY Maryland P.G.						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2902 Walters Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Stueckler				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie Henson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-01-2604		17. INFORMANT ADDRESS Silver Joseph Meredith 95 E. Wayne Ave. Spring Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) <del>Myocardial Infarction</del> - <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pernicious anemia, Diabetes mellitus, Metabolic acidosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>12/24/81</u> , 19____, to <u>1/8/82</u> , 19____, that (I) <u>(we)</u> lost saw the deceased <u>live on</u> <u>1/5/82</u> , 19____, and that in <u>(my)</u> <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above <u>(I)</u> <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Debra B Goldberger</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>1/9/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DEBRA B GOLDBERG</u>				22e. ADDRESS <u>1106 SPRING ST, SILVERSPRING MARYLAND</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1-11-1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>				23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR NAME ADDRESS <u>George P. Kalas Funeral Home</u> <u>6160 Oxon Hill Rd. Oxon Hill, Md.</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 12 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Frances Jan Whitham</u>			

1-11-1991 From David C. Manning

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
CHARLES A. MERRILL					1 JAN-31-82					440 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		Caucasian		DEC. 10, 1906		75 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
KANSAS		U.S.A.				Montgomery County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		Washington Adventist Hospital				DISPLAY MANAGER			DEPARTMENT STORE		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		525 THAYER AVENUE #211				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
YES WWII					443-01-7560		MRS. MILDRED P. BREEN 4091 ELMWOOD AVENUE LOUISVILLE, KENTUCKY				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Aspiration, respiratory failure										30 min	
5303 DUE TO, OR AS A CONSEQUENCE OF (b) Esophageal stricture										Indefinite	
DUE TO, OR AS A CONSEQUENCE OF (c) COPD										Long-standing	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
Atherosclerotic heart disease, Congestive heart failure											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET		CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JAN 30 '82, 1982, to JAN 31, 1982, that (I) (we) lost saw the deceased alive on JAN 31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
Norton Elson		MD				31 Jan 82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
NORTON ELSON		6525 Belcrest Road Hyattsville MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE			
CREMATION		FEB/ 1/82		CEDAR HILL CREMATORY		SUITLAND		P.G. CO. MARYLAND			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
CHAMBERS FUNERAL HOME		SILVER SPRING, MD.				FEB 9 1982					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS SUSPECTED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR Items #18a-22a Film										DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- STATE REGISTRAR G565 3/30/82										MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)										REG. NO.									
FIRST MIDDLE LAST GARY LEWIS MERRITT										2a. DATE KNOWN OF DEATH ESTIMATED 1-4-82 19									
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 21 53		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 1-7-82 19		2b. HOUR M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.							
10. CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11925 Parklawn Drive Apt. T-1				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) antique dealer				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11925 Parklawn Dr. #T1									
14. FATHER'S NAME FIRST MIDDLE LAST Lewis B Merritt						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Ann Rest													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 218-54-6398		17. INFORMANT ADDRESS Bethesda, Md. Catherine Ann Anthony 5001 Sentinel Dr.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Narcotism Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Koroll, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 1-8-82							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Koroll, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE 1/11/82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland									
24. FUNERAL DIRECTOR NAME Lydon Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR JAN 13 1982		25b. REGISTRAR'S SIGNATURE Name Jan											

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Antique dealer

1005 Parklawn Dr. #1

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Beacon, N.Y.

Catherine Ann Anthony 2001 Benjamin

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02268	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Irene Edna Merson										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1/8 19 82	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jun. 19, 1912	6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/8 19 82	2b. HOUR P. M. 9:00 P. M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 601 Hermleigh XXXXX Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 601 Hermleigh XXXXX Road			
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT LEE REID				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE REID							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-46-6991		17. INFORMANT EDWARD EUGENE MERSON		ADDRESS HUSBAND SAME AS 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cinoma of the breast.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		TITLE (SPECIFY) Deputy MEDICAL EXAMINER		DATE SIGNED 1/9/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/12/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD. W. SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 12 1982		25b. REGISTRAR'S SIGNATURE 					



• *Small*

0.84, 0.79, 0.76, 0.72

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 6 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MEYEROWITZ, JENNIE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-12-82</b>				2b. HOUR <b>9:41 M</b>			
3. SEX <b>F</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 19, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lithuania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6121 Montrose Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Israel Lavin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Glicka Block</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>228-62-5458</b>		17. INFORMANT ADDRESS <b>Irving Meyerowitz-2611 Ross Rd.-Ch.Ch., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MYOCARDIAL INFARCT</b> (c) <b>CORONARY ARTERY DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SENILE DEMENTIA OF ALZHEIMER'S TYPE</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/21/79</b> to <b>1/12/82</b> , that (I) (we) last saw the deceased alive on <b>1/12/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>D.D. Patel</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.D. PATEL</b>				22e. ADDRESS <b>6121 MONTROSE RD, ROCKVILLE, MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church-Fairfax-Va.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>				25a. DATE OF REGISTRATION <b>JAN 19 1982</b>				25b. REGISTRAR'S SIGNATURE <b>Charles J. Nathan</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF THE DEATH IS SUSPECTED TO BE A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Donald Lee Miller</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>1/10/82</b>			2b. HOUR <b>0839</b>		
3. SEX <b>Male</b>	4. RACE <b>Cauca.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7, 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>56 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD <b>Jan. 10, 1982</b>	7d. HOUR <b>8:30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>		
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>		12b. KIND OF BUSINESS <b>Minister of Music</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>17226 King James Way #301</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Allen Miller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pearl Alderson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>360 16 7636</b>		17. INFORMANT ADDRESS <b>Mrs. Robert Lapp Carlinville, Ill.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> 8160 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Acute Intoxication - Alcohol</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>9:25 P.M. 1 9 1982</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) <b>Lost Control of car drove in lake</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Lake Wheatstone Lake Mont. Village Gaithersburg Mont.</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Old Georgetown Rd. Bethesda Md.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John G. Ball</b>		TITLE (SPECIFY) <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>Jan 10, 1982</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>		ADDRESS <b>7936 Old Georgetown Rd. Beth. Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 13, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria Virginia</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Virginia</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 2 7 1					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST <b>Helen Phyllis Miller</b>										<b>Jan. 20, 1982</b>				<b>10:00 P</b>	
3. SEX <b>female</b>			4. RACE <b>white</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>July 16, 1930</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.						
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>918 Viers Mill Road</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>918 Viers Mill Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas M. Craven</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Coomer</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>279-26-9951</b>			17. INFORMANT ADDRESS <b>A Wm. W. Miller same as 13e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE (STROKE) post</b> <b>5728</b> DUE TO, OR AS A CONSEQUENCE OF <b>COMMUNICABLE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CONGESTIVE HEART FAILURE, RECURRENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>HEPATIC FAILURE, CHRONIC</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <b>POLYCYTIC DISEASE INVOLVING LUNG, PANCREAS, KIDNEY</b>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>5-18</b> , 19 <b>81</b> , to <b>1-04</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <b>Hector C. Asuncion</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/21/82</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hector C. Asuncion</b>						22e. ADDRESS <b>19601 Fisher Ave. Poolesville, Md. 20837</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1/22/82</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria Fairfax Virginia</b>						
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1982</b>			25b. REGISTRAR'S SIGNATURE <b>James J. Matthews</b>						
1331 Rockville Pike Rockville, Maryland 20852															

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6. *Conclusions*

Ergonomics

Category	Score	Comment
Category 1	100	Excellent
Category 2	90	Very Good
Category 3	80	Good
Category 4	70	Fair
Category 5	60	Poor
Category 6	50	Very Poor
Category 7	40	Terrible
Category 8	30	Disastrous
Category 9	20	Catastrophic
Category 10	10	Unacceptable
Category 11	0	Unacceptable

Abstracts



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Roy RAYMOND MILLER			2a. DATE OF DEATH MONTH DAY YEAR 1-3-82			2b. HOUR 7:30A			
3. SEX MALE		4. RACE W HITE		5. DATE OF BIRTH MONTH DAY YEAR 06-01-00		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MONTANA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED/mechanic		12b. KIND OF BUSINESS OR INDUSTRY MECHANIC	
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 704 ROSEMERE AVE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN CUMMINGS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 213-12-1693		17. INFORMANT LOUISE B. MILLER		ADDRESS SAME AS 13		WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Diabetes mellitus, Encephalomalacia</u>									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/22/81</u> to <u>1-3-82</u> , that (I) (we) lost saw the deceased alive on <u>1-2-82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Jerome Schwanke, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEROME SCHWANKE, MD				22e. ADDRESS 11661 New Hampshire Ave. Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/6/82		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.			
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 8 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1503 BP

MASSACHUSETTS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 7 3			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph Frederick Moore, Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 82</b>		2b. HOUR <b>3:05 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 9, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Pr Geo</b>		13c. CITY OR TOWN <b>Suitland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4830 Eastern Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Moore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor A. Benedict</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>717 07 7126</b>		17. INFORMANT ADDRESS <b>Daughter Joan A. Henderson 1731 Shore Drive Edgewater, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> 5990 DUE TO, OR AS A CONSEQUENCE OF (b) <b>URINARY TRACT Infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Months</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH <b>4 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>DECUBITI</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21g. I certify that (I) (the hospital) attended the deceased from <b>July 81</b> to <b>1/28/82</b> , and that (I) (we) lost the deceased alive on <b>1/28/82</b> 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22a. SIGNATURE <b>Thos G. Ward M.D.</b>				22b. ADDRESS <b>6116 ROBINWOOD, Bethesda Md 20817</b>				22c. DATE SIGNED <b>1/29/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>				22e. ADDRESS <b>6116 ROBINWOOD, Bethesda Md 20817</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>2Feb1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md</b>			
24. FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm Funeral Home</b>				24b. ADDRESS <b>Suitland, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thos G. Ward</b>			

MEDICAL CERTIFICATION

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Handwritten text, possibly a signature or date, appearing vertically in the center-right area.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202274			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) <b>RENZA C. MUREAN</b>				2b. HOUR <b>4:45 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 2 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Retirement Center</b>		12a. USUAL OCCUPATION (If not working, give occupation) <b>housewife</b>		12b. KIND OF BUSINESS OR OCCUPATION <b>own home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. STREET ADDRESS <b>609 Northwood Terrace.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Roberto Castelli</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Beneditti</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>211-01-7939</b>		17. INFORMANT ADDRESS <b>666 Houston Ave., Tk. Pk. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MALIGNANCY - RIGHT LUNG</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b>			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>ALZHEIMER'S DISEASE; SACRAL DECURTUS</b>							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-8 1982</b> to <b>1-8 1982</b> , that (I) (we) last saw the deceased alive on <b>1-8 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>John P. Nason, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-8-82</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN P. NASON</b>				22e. ADDRESS <b>800 OERSTING DR. SILVER SPRING</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>Jan. 11, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Hines, Rinaldi Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James Van Nuthen</b>	

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257-001

WASHINGTON, D.C. (UPI) —

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

DHMH-17  
(VR A15 ME (5))  
15M2/80

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02275			
1. DECEASED NAME (TYPE OR PRINT) <b>Ambrozine A. Morris</b>										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Jan. 22, 1982</b>		2b. HOUR OF DEATH <b>5:45 P.M.</b>			
3. SEX <b>A</b>		4. RACE <b>BLK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04.31 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>Jan 22, 1982</b>		2d. HOUR <b>5:45 P.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Jamaica</b>				7b. CITIZEN OF WHAT COUNTRY? <b>Jamaican</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bt. Spg.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>				13b. COUNTY <b>Montg</b>		13c. CITY OR TOWN <b>Bt. Spg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1008 Kathryn Dr.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Kennedy</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor McFarlane</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NONE</b>				16b. SOCIAL SECURITY NO. <b>212 78 4576</b>				17. INFORMANT ADDRESS <b>Gloria Worsley (Daughter) Same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis.</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <b>Chronic Myocardial Dis.</b>												<b>Yrs.</b>			
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
<b>None</b>															
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER				DATE SIGNED <b>Jan 22, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>				ADDRESS <b>1919 Seminary Rd. S.S.Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>S.S. Mont. Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi</b>				ADDRESS <b>F.H. 11800 N.H. Ave. S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1982</b>				25b. REGISTRAR'S SIGNATURE <b>Frances Santhorn</b>			



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LETTER IN BOMB

*[Handwritten signature]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 7 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HUGH M. Morris</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-31-82</b>		2b. HOUR MIN. <b>12 a</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>73</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Health Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Serv. Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	
13a. USUAL RESIDENCE (IF MARRIED, HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) FIRST MIDDLE LAST <b>Max Morris</b>		13b. CITY OR TOWN OF DEATH <b>Washington D.C.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3048 Oliver St. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Greene Morris</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW II</b>		16b. SOCIAL SECURITY NO. <b>212 05 0559</b>		17. INFORMANT ADDRESS <b>Donnayton Woodbine MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> <b>3320</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Severe fluid &amp; electrolyte probly</b> (c) <b>Severe debility for chronic brain sys</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>weeks</b> <b>yes</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Parkinsonism, Anemia, Recent septicemia</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 19 81</b> , to <b>1/31 19 82</b> , that (I) (we) last saw the deceased alive on <b>1/28 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard Delaney</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/31/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD DELANEY MD</b>				22e. ADDRESS <b>4323 HARVARD ST SE. 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Princess Jean Kuthers</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 2 7 7			
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KARL NMN MOSS					2a. DATE OF DEATH MONTH DAY YEAR January 6, 1982				2b. HOUR 5:10 P.M.				
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 18 1903		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.							
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON				12a. USUAL OCCUPATION (TYPE OF BUSINESS, INDUSTRY, OR SERVICE) TAILOR DRY CLEANER		12b. KIND OF BUSINESS OR INDUSTRY CLOTHES					
13a. STATE MARYLAND					13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 8002 EASTERN DRIVE	
14. FATHER'S NAME FIRST MIDDLE LAST YEHUDA MOSS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE VENTA DRISNOOSKY								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO					16b. SOCIAL SECURITY NO. 57-44-1483		17. INFORMANT 190855 MONTICELLO AVENUE DANIEL SOSNOWIK, SILVER SPRING, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) (1) ATRIAL FIBRILLATION (2) SENILE DEMENTIA													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/1/81, to 1/6/82, that (I) (we) lost saw the deceased alive on 1/6/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE M.D. [Signature]				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/6/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.D. PATEL				22e. ADDRESS 6121 MONTROSE RD. ROCKVILLE, MD.									
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 1/7/1982		23c. NAME OF CEMETERY OR CREMATORY NATIONAL CAPITOL HEBREW CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C.					
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.						25. DATE REC'D. BY REGISTRAR JAN 11 1982		26. REGISTRAR'S SIGNATURE [Signature]					

MEDICAL CERTIFICATION

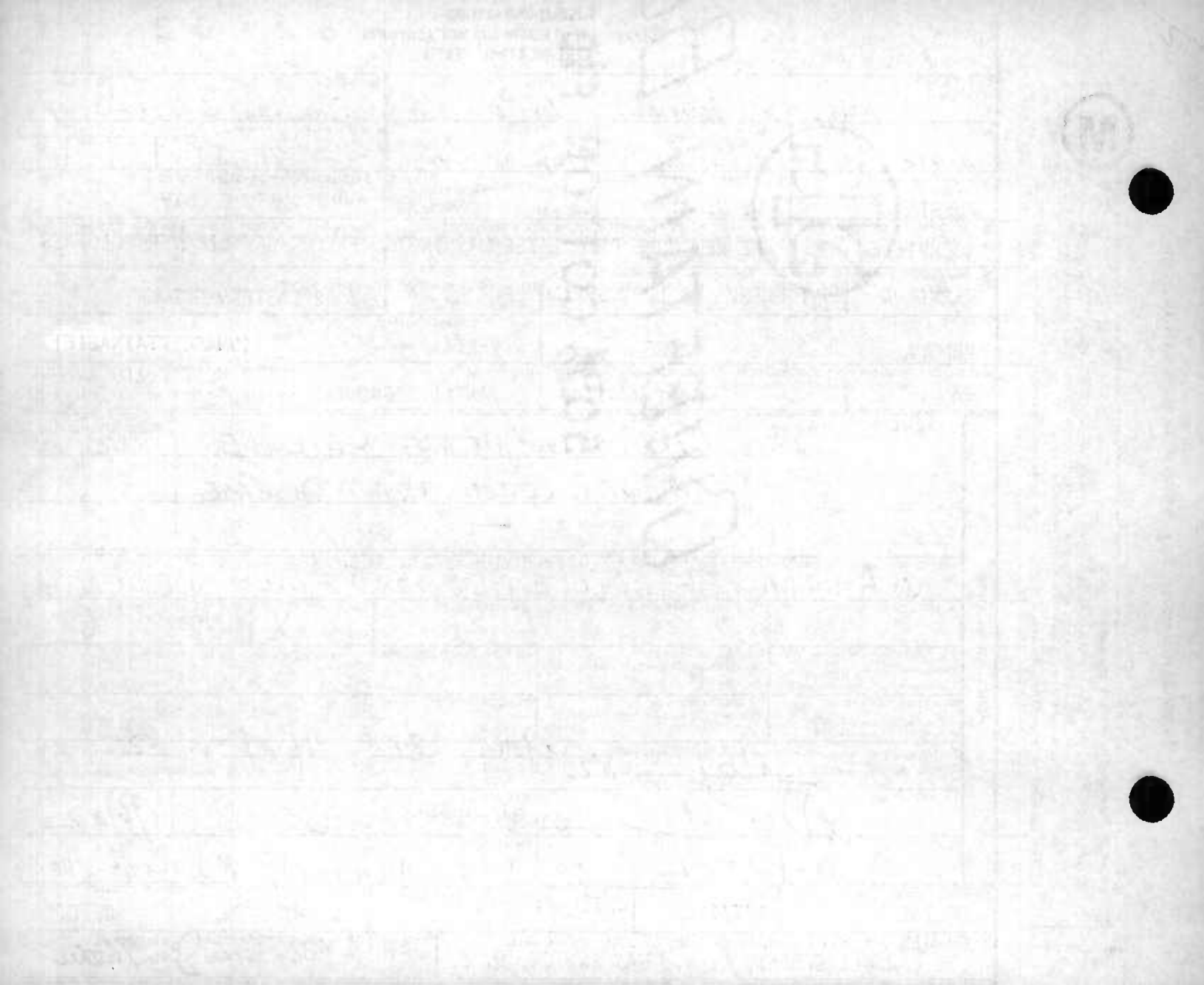
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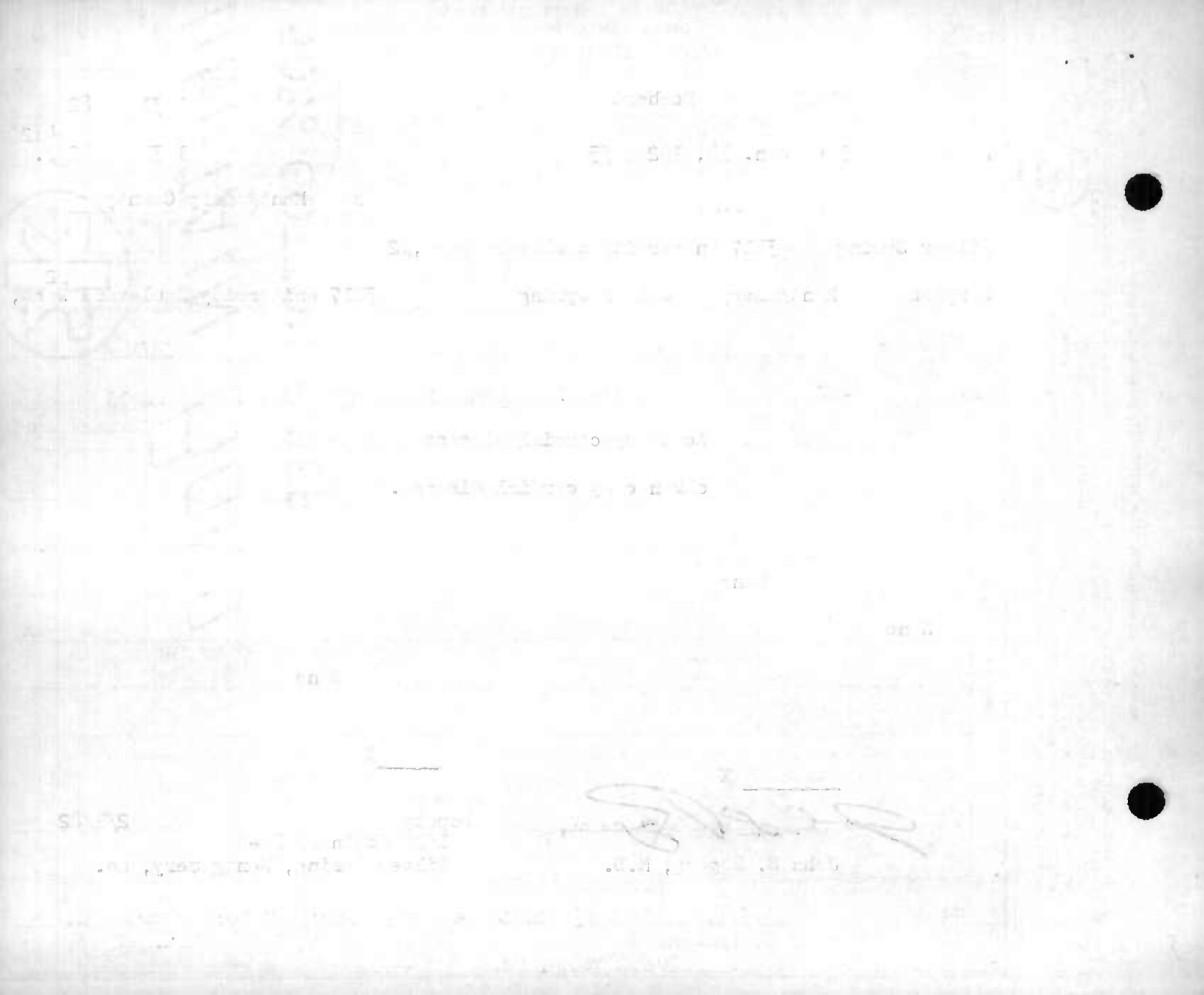


DHMH-17  
(VR A15 ME (5))  
15M 2/80

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 2 2 7 8							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH				2b. HOUR					
Charles Herbert Moy										<input checked="" type="checkbox"/> MONTH DAY YEAR 1/31 19 82				4:20 P. M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Male		Yellow		Jan. 14, 1929		53 YRS.		MONTHS DAYS		HOURS MIN.		1/31 19 82		P. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Washington, D.C.				U.S.A.								Montgomery County							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				3117 University Boulevard West, #2				Budget Officer				H.F.W.							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		#2 3117 University Boulevard West,									
14. FATHER'S NAME				FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME				FIRST		MIDDLE		LAST	
Charles								Moy		See								Chin	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS									
Yes				KOREA		579-34-6577				Darrell L. Moy Son Same as 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																			
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Acute myocardial disease																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b) chronic myocardial disease.																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
None																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															
None																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
								None											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER															
				1919 Seminary Road															
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
John S. Rogers, M.D.				Silver Spring, Montgomery, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				Feb. 4, 1982		Gate of Heaven Cemetery				Silver Spring Mont. Md.									
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Francis J. Collins				FEB 8 1982				Francis J. Collins											
500 University Blvd., W. Silver Spring, Md.																			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joyce Alvera Mullaney										2a. DATE KNOWN OF DEATH ESTIMATED 1.6.1982										2b. HOUR 12:45 A.M.	
3. SEX Female		4. RACE Cauca.		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1925		6. AGE (IN YEARS) (LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 1.6.1982		2d. HOUR 1:30 A.M.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.									
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary				12b. KIND OF BUSINESS OR INDUSTRY Engineering Firm									
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9616 Pinkney Court											
14. FATHER'S NAME FIRST MIDDLE LAST George H. Hill						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel A. Furman															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 485 16 4709		17. INFORMANT Husband John Henry Mullaney				ADDRESS Same as item 13 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER				DATE Jan 6, 1982									
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				5936 Old Georgetown Rd.				Bethesda, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland											
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY HOMES, P.A., ROCKVILLE, MARYLAND								25a. DATE REC'D. BY REGISTRAR JAN 11 1982						25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>							

10

RECEIVED FOR THE



Central Intelligence Agency  
Carlin Vasseler, Director

John D. Bell

Deputy

Jan 11 1965

JAN 11 1965 Stamp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified (see item 18).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <u>Catherine</u> <u>T.</u> <u>Munphy</u>					2a. DATE OF DEATH MONTH <u>1</u> DAY <u>19</u> YEAR <u>82</u>				
3. SEX <u>F.</u>		4. RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>1</u> DAY <u>15</u> YEAR <u>04</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>78</u> YRS		2b. HOUR <u>5.55 PM</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Mass.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery Co.</u> MD.			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Colonial Villa Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>School Teacher</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>D.C.</u>		13b. CITY OR TOWN <u>Wash. D.C.</u>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <u>5024 Belt Road</u>			
14. FATHER'S NAME FIRST <u>John P.</u> MIDDLE <u>Murphy</u> LAST <u></u>					15. MOTHER'S MAIDEN NAME FIRST <u>Deborah</u> MIDDLE <u>O'Connor</u> LAST <u></u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>None</u>		16b. SOCIAL SECURITY NO. <u>027 18 1956</u>		17. INFORMANT ADDRESS <u>John Murphy (Brother) Same as above</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>4100</u> IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> Sudden DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION <u>          </u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>          </u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>          </u> <u>          </u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>          </u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>          </u>		21f. LOCATION STREET <u>          </u> CITY OR TOWN <u>          </u> COUNTY <u>          </u> STATE <u>          </u>					
22a. I certify that (I) (the hospital) attended the deceased from <u>Feb</u> <u>12-8</u> <u>1981</u> to <u>Jan 19</u> <u>1982</u> , that (I) (we) lost the deceased alive on <u>12-8</u> <u>1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>P.P. Andrews M.D.</u> DEGREE <u>M.D.</u>					22c. DATE SIGNED <u>1-19-82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P.P. ANDREWS</u>					22e. ADDRESS <u>4977 Battery Lane Bethesda Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/23/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Leicester, Mass.</u> COUNTY <u>          </u> STATE <u>          </u>			
24. FUNERAL DIRECTOR <u>Hines/Rinaldi F.H. 11800 New Hamp. Ave. S.S. Md.</u>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>JAN 21 1982 James J. Thibault</u>				

Medical Examiner Natyfid was authorized to sign  
PPA

Medical Examiner Natyfid was authorized to sign  
PPA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Jacob Nash</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 30 1982</b>		2b. HOUR <b>1:13 p.m.</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 27 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
13a. STATE <b>Virginia</b>				13b. CITY OR TOWN <b>Frederick</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>Rtl BX319, Winchester, VA.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Boston Nash</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Feezer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>				16b. SOCIAL SECURITY NO. <b>554-34-1673</b>		17. INFORMANT ADDRESS <b>Donald K. Bane 8483 Greenbelt #102 MD. 20770</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stage D2 Prostatic Adeno Carcinoma</b> <b>1850</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-28-81</b> , 19____, to <b>1-30-82</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-30-82</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gary G. Sladek</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-30-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary G. Sladek</b>				22e. ADDRESS <b>UNMC, BETHESDA, MD 20814</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Shawandosh Mem Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Winchester Frederick VA.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

MEDICAL CERTIFICATION



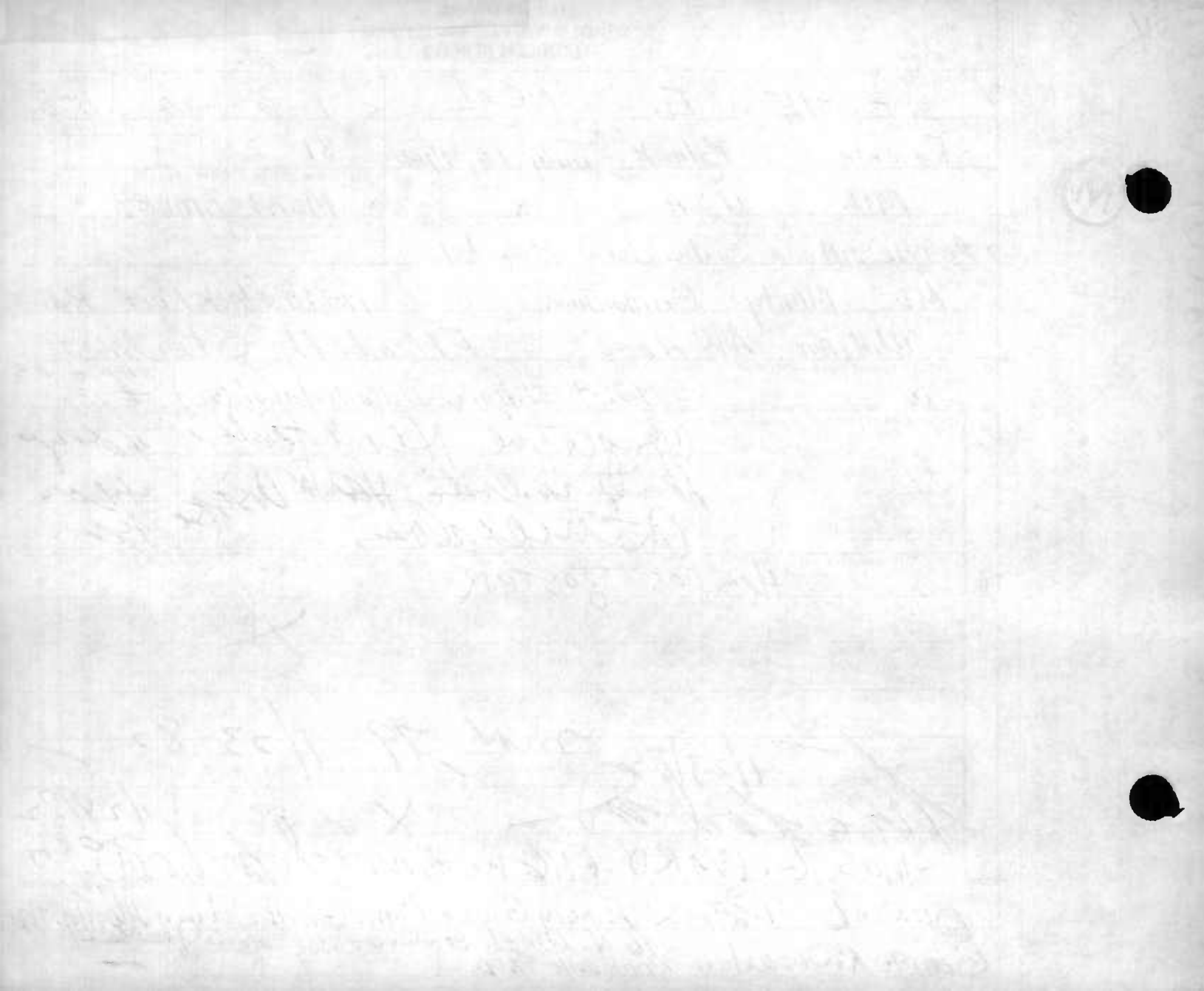
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELSIE E. NEAL</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-23-82</b>			2b. HOUR <b>11:25 M</b>	
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 13, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Germantown</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17520 Black Rock Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Mc Abee</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth STEWART</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-26-9855</b>		17. INFORMANT ADDRESS <b>Eleanor Duvall (daughter) #13</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myocardial Infarction</b> PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Herpes Zoster</b>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>1/23/82</b> to <b>1/23/82</b> , that (I) (we) last saw the deceased alive on <b>1/23/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (or we told) (did not) view the body of the deceased.									
22b. SIGNATURE <b>Thos G. Ward</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/24/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>		22e. ADDRESS <b>6116 Robinwood, Bethesda, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-29-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Emory Grove Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gaithersburg Montg. Md.</b>			
24. FUNERAL DIRECTOR <b>George R. Snowden</b>		24b. ADDRESS <b>246 N. Wash St. Rockville, Md.</b>		24c. DATE REC'D. BY REGISTRAR <b>1-30-82</b>					



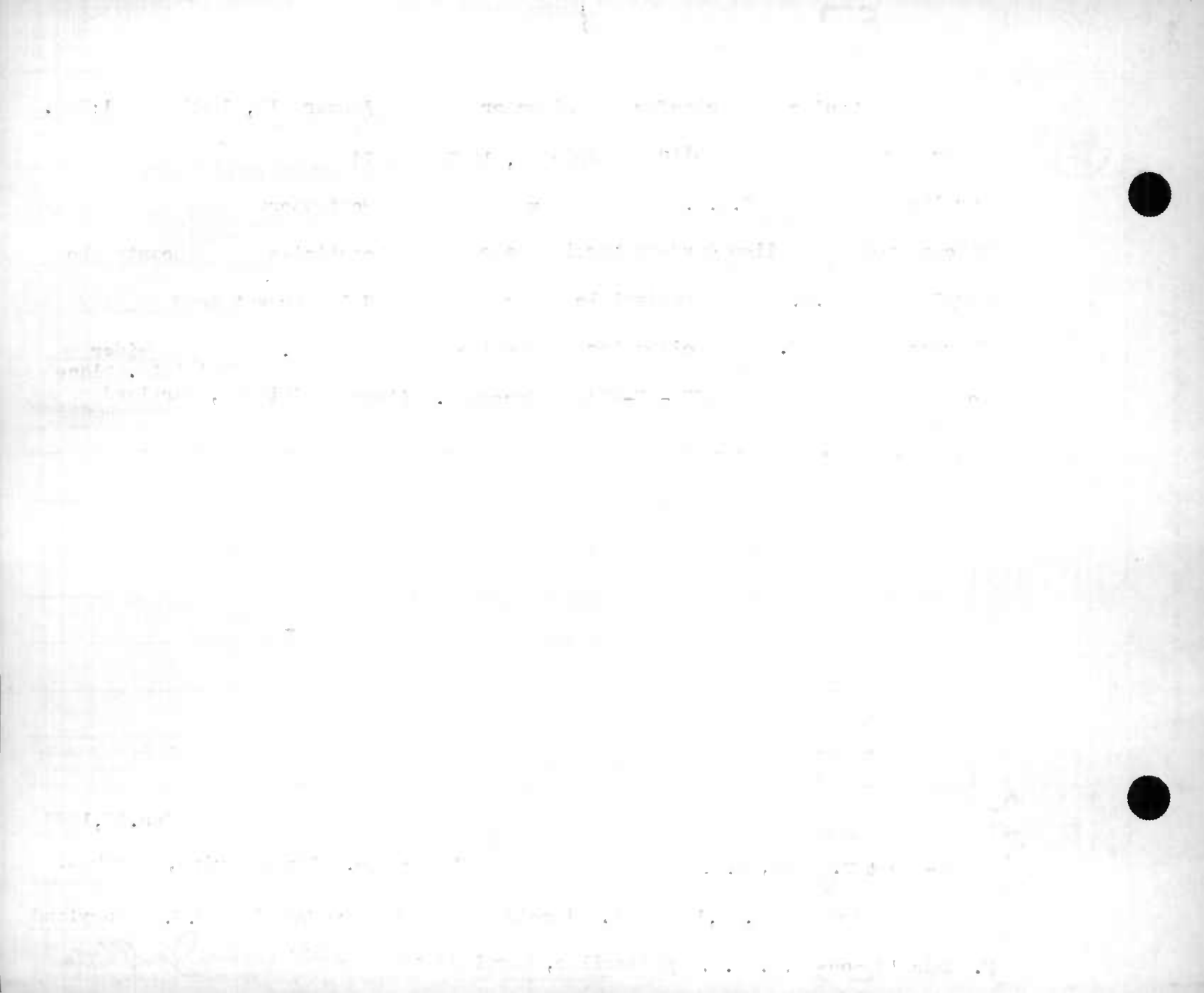


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 20M  
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 8 3					
1. DECEASED NAME (TYPE OR PRINT) <b>Louise Schaefer Neidecker</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 13, 1982</b>				2b. HOUR <b>1:30P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 29, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>74</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
12. CITY OR TOWN OF DEATH <b>Takoma Park</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sligo Gardens Nursing Home</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Beautician</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Beauty Shop</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5814 Sargent Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles G. Heitmuller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Louise E. Heider</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO <b>578-05-2740</b>		17. INFORMANT <b>Teresa S. Wilcox</b>		ADDRESS <b>5911 14th. Place Chillum, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4409</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-13</b> , 19 <b>82</b> , to <b>1-13</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1-13</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. Snow MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Jan. 17, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Margaret T. Snow, M.D.</b>				22e. ADDRESS <b>9013 Flower Ave. Silver Spring, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 18, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>F. Gasch's Sons F.H. P.A. Hyattsville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 2 2 8 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>MARY MARGARET Nicholas</i>				2a. DATE OF DEATH MONTH DAY YEAR 1-27-82			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR 8 15 05		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D. C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Pr. Geo.</i>		13c. CITY OR TOWN <i>W. Hyattsville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nellie E. Flaherty</i>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>			
16a. SOCIAL SECURITY NO. <i>216-40-5843</i>		17. INFORMANT <i>Daughter</i>		ADDRESS <i>1708 Hampshire Green Silver Spring, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line, or (1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (14), (15), (16), (17), (18), (19), (20), (21), (22), (23), (24), (25), (26), (27), (28), (29), (30), (31), (32), (33), (34), (35), (36), (37), (38), (39), (40), (41), (42), (43), (44), (45), (46), (47), (48), (49), (50), (51), (52), (53), (54), (55), (56), (57), (58), (59), (60), (61), (62), (63), (64), (65), (66), (67), (68), (69), (70), (71), (72), (73), (74), (75), (76), (77), (78), (79), (80), (81), (82), (83), (84), (85), (86), (87), (88), (89), (90), (91), (92), (93), (94), (95), (96), (97), (98), (99), (100), (101), (102), (103), (104), (105), (106), (107), (108), (109), (110), (111), (112), (113), (114), (115), (116), (117), (118), (119), (120), (121), (122), (123), (124), (125), (126), (127), (128), (129), (130), (131), (132), (133), (134), (135), (136), (137), (138), (139), (140), (141), (142), (143), (144), (145), (146), (147), (148), (149), (150), (151), 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CHILDREN

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*Cleared by M.D. 1-5-82*

0804 BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 2 8 5			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>William Hall Slack Nicholson</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>January -2-82</i>		2b. HOUR 2:15 A.M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 3, 1914</i>		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Representative		12b. KIND OF BUSINESS OR INDUSTRY H.U.D.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Gaithersburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19413 Brassie Place #201	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Leonard Nicholson, Jr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary Slack</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-26-0635		17. INFORMANT Frances S. Nicholson, Wife, Same as item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <del>HEART</del> CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE VENTRICULAR SEPTAL RUPTURE 24 hrs. DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE INFERIOR WALL INFARCTION 24 hrs.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>1/1/82</i> to <i>1/2/82</i> , that (2) we last saw the deceased alive <i>1/1/82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <i>Roger Stevenson, Jr.</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/2/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROGER STEVENSON, JR MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 5, 1982		23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 7 1982		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>	





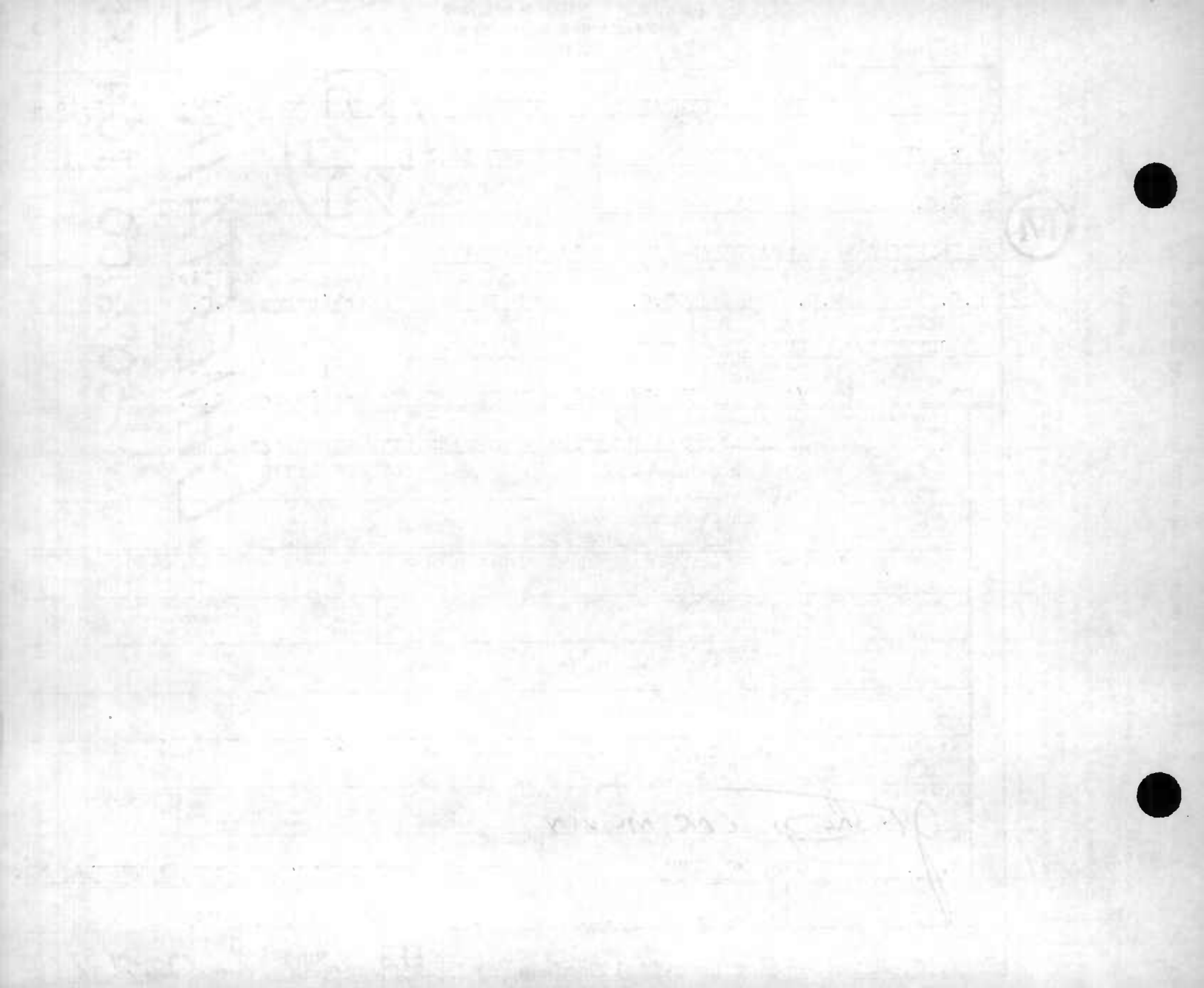
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers: Pages 1 and 2 should be filed with the Division of Vital Records within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 2 2 8 6					
1. FOR STATE REGISTRAR										
1 DECEASED NAME (TYPE OR PRINT) JANINA LYNNAE NIXON					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1982					
3 SEX FEMALE					2b. HOUR 9:49 PM					
4 RACE NEGRO					6 AGE (IN YEARS LAST BIRTHDAY) MONTH DAY YEAR DECEMBER 29, 1981					
5 DATE OF BIRTH					7a. BALTIMORE CITY OR COUNTY OF DEATH					
6 BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.					7b. CITIZEN OF WHAT COUNTRY? USA					
7c. CITY OR TOWN OF DEATH BETHESDA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER					9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
13a. STREET ADDRESS 2031 1st Street Washington, D.C.										
14. FATHER'S NAME FIRST MIDDLE LAST JEFFERY LYNN SMITH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANINE RANEE NIXON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO N/A					16b. SOCIAL SECURITY NO. 578-76-4863					
17 INFORMANT 2031 1st Street JANINE NIXON; Washington, D.C.										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7690 HYALINE MEMBRANE DISEASE WITH NECROTIZING ENTEROCOLITIS					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 29 DECEMBER 19 81, to 24 JANUARY 19 82, that (I) (we) lost the deceased alive on 24 JANUARY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J. W. THORPE CDR, MC, USN					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. W. THORPE CDR, MC, USN					22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-29-82		23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Landover, Md.			
24. FUNERAL DIRECTOR NAME Robt. G. Mason Funeral Home-1661 Good Hope Rd., S.E. D.C.					25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 2 8 7			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Edward Noonan</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 7, 1982</b>					2b. HOUR <b>9:40</b> a.m.			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 2 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>263 Congressional Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired A T</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>&amp; T Telephone</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>263 Congressional Lane #712</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Joseph Noonan</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca Harrison</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT ADDRESS <b>A Kathryn F. Noonan same as 13e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Thrombosis of left middle cerebral artery</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic heart disease with left bundle branch block</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>38 days</b> <b>several years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Atherosclerotic heart disease with left bundle branch block</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> , 19 <b>75</b> , to <b>1/7</b> , 19 <b>82</b> , that (I) <del>was</del> last saw the deceased alive on <b>1/6</b> , 19 <b>82</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above.													
22b. SIGNATURE <b>Dr. Michel Healy</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/7/82</b>					
22d. PHYSICIAN'S NAME <b>Dr. Michel Healy</b>				22e. ADDRESS <b>5652 Shields Dr. Bethesda, Maryland 20817</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>							
24. FUNERAL DIRECTOR'S NAME <b>Tyson Wheeler Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1982</b>				25b. REGISTRAR'S SIGNATURE <b>James J. ...</b>					
1331 Rockville Pike <b>Rockville, Maryland</b>													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-1650M 1/81  
(VRA 15, 4)

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 2 8 8	
1. DECEASED NAME (TYPE OR PRINT)			REG. NO.		
1. DECEASED NAME (TYPE OR PRINT) Wilhelmina E. Norrell			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1982		2b. HOUR 8:45 pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 31, 1902	6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9710 Bristol Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 9710 Bristol Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST James - Ewen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsbeth - Marr			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None		16b. SOCIAL SECURITY NO. 041-02-0631		17. INFORMANT ADDRESS Thomas Norrell 9710 Bristol Ave. Silver Spring, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) ? DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 47, to Jan. 31, 19 82, that (I) (we) last saw the deceased alive on Jan. 29, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William D. Aud MD DEGREE 22c. DATE SIGNED Jan. 31, 1982				22e. ADDRESS 9006 Colesville Rd. Silver Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Feb/1/82	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, P.G. Co., Maryland
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Maryland				25a. DATE REC'D. BY REGISTRAR FEB 5 1982	

William D. and M. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6000

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>DOROTHY A. NORTON</b>					2a. DATE OF DEATH MONTH <b>JANUARY</b> DAY <b>27</b> YEAR <b>1982</b>				
3 SEX <b>FEMALE</b>					2b. HOUR <b>6:00 P.M.</b>				
4 RACE <b>White</b>					5 DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>19</b> YEAR <b>1897</b>				
6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.					7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D. C.</b>					7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Rockville</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac alley Nursing Home</b>				
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a STATE <b>Md.</b>					13b. COUNTY <b>Montgomery</b>				
13c. CITY OR TOWN <b>Bethesda</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13e. STREET ADDRESS <b>7505 Democracy Blvd.</b>					14. FATHER'S NAME FIRST <b>Charles</b> MIDDLE <b>E.</b> LAST <b>Wood</b>				
15. MOTHER'S MAIDEN NAME FIRST <b>Frances</b> MIDDLE <b></b> LAST <b>Twiford</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>577-09-5503 D</b>					17 INFORMANT <b>Janice Norton. Same as item 13.</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Insufficiency</b> <b>4379</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO OR AS A CONSEQUENCE OF (b) <b>Generalized Cerebral Sclerosis</b> DUE TO OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>15 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Urinary Tract Infection</b>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from <b>12/24/81</b> to <b>1/27/82</b> 19____, that (I) (we) last saw the deceased alive on <b>1/27/82</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Henry P. Scruggs MD</b>					22b. DATE SIGNED <b>1/27/82</b>				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Henry P. Scruggs MD</b>					22d. ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>2/1/1982</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>					23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Maryland</b> STATE				
24 FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> ADDRESS <b>3130 Wisconsin Ave., N.W. Wash., D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>				
25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>									



2130 Macdonald Ave., N.E., Wash., D.C.  
 Joseph Lawrence's Sons Inc.  
 2/1982 Cedar Hill Cemetery

Butland, Maryland.

707-02-7503 B Janice Norton. Same as item 13.

Charles

Wood

Frances

Twiford

Ms.

Montgomery

Montgomery

7505 Democracy Blvd.

Rockville

Montgomery

Montgomery

Montgomery

Home

U.S.

U.S.

XX

Montgomery

White

Montgomery

Montgomery

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02290	
1. FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William nmn Norton</b>										MONTH DAY YEAR <b>Jan 3 1982</b>	
2. SEX RACE DATE OF BIRTH AGE (IN YEARS) IF UNDER 24 HRS. MONTH DAY YEAR LAST BIRTHDAY MONTHS DAYS HOURS MIN.										7b. DATE ESTI-MATED	
<b>Male White Nov. 30, 1924 57 YRS.</b>										<b>Jan 3 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>Wash. D.C. USA</b>										<b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY	
<b>Rockville 1903 Stanley Avenue</b>										<b>Washington Gas Light Co.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS	
<b>Maryland Montgomery Rockville</b>										<b>1903 Stanley Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
<b>Cornelius J. Norton May Alaska</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS											
<b>yes WW II 579 20 6633</b>										<b>Deris Mae Norton same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John B. Ball</b> M.D. TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER DATE SIGNED <b>Jan 3, 1982</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b> ADDRESS <b>Old Georgetown Rd. Bethesda, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE											
<b>Burial 1/6/82 Parklawn Memorial Park Rockville, Maryland</b>											
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
<b>Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland 20852</b>										<b>JAN 6 1982</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8202291							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen M. NOVASOSKY					2a. DATE OF DEATH MONTH DAY YEAR 1-31-82			2b. HOUR 10 <sup>30</sup> P.M.	
1. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 20, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Rockville Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse		12b. KIND OF BUSINESS OR INDUSTRY nursing	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4624 Bettswood Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Zolkosky					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Matilda J. Smith				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 199-36-9968		17. INFORMANT ADDRESS Carolyn Jennings same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 5621 DUE TO, OR AS A CONSEQUENCE OF (b) Electrolyte Imbalance Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Acute Myocardial Infarction Complicated by heart failure 2 days PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Suddity.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (i) (this hospital) attended the deceased from 1/10 to 1/31 1982, that (i) (we) last saw the deceased alive on 1/22/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not see the body after death, so state.)									
22b. SIGNATURE THOMAS G. GARVEY II, MD					DEGREE MD		22c. DATE SIGNED 1/31/82		22d. ADDRESS 11510 Old Georgetown Rd. Rockville, Md.
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/3/82		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Scranton, Pennsylvania			
24. FUNERAL DIRECTOR Lyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR FEB 8 1982		25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION

29

BP



BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 2 9 2			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR A M	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR A M			
ANNIE ELIZABETH NULL					JANUARY 31, 1982					4:00 A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
Female		White		July 7, 1925		56							
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Kentucky		U.S.A.				Montgomery County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Clinical Center, NIH, Beth., Md				Waitress		Restaurant					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
Maryland		P.G. Co.		Riverdale				5800 - 48th Ave., 20737					
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Reed - Millar					Etta - Sisco								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		None		400-32-9646		Gregory Null (son)		4900 Battery Ln. #110 Bethesda, Md., 20814					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) — <u>Bronchopneumonia</u>										Days			
1749 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										Months			
b) — <u>Widely metastatic cancer of breast</u>													
DUE TO, OR AS A CONSEQUENCE OF													
c) —													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
			P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 28, 1981</u> , to <u>January 31, 1982</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>January 31, 1982</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE					DEGREE		22c. DATE SIGNED						
Susan E. Bates M.D.							1/31/82						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS								
Susan E. Bates, M.D.					National Institutes of Health Clinical Center, Bethesda, Md., 20205								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			Feb/3/82		Ft. Lincoln Cemetery		Brentwood, P.G. Co., Maryland						
24. FUNERAL DIRECTOR NAME						ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Chambers Funeral Home						Riverdale, Maryland		FEB 3 1982					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					8 2 0 2 2 9 3						
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST DONALDA H. O'CONNELL					MONTH DAY YEAR 1 - 30 - 82					6:22 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		WHITE		MONTH DAY YEAR 8-17-07		74 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
PENNSYLVANIA		U.S.A.				MONTGOMERY COUNTY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SILVER SPRING		HOLY CROSS HOSPITAL				HOUSEWIFE		HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		FREDERICK		FREDERICK		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5902 QUINN ORCHARD ROAD			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST LEOPOLD POIRIER					FIRST MIDDLE LAST (UNKNOWN) TRUDEZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					NONE		161-28-5749 MRS. ALENHOZE (DAUGHTER) SAME AS #13.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>4920</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal Bleeding</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
			HOUR A.M. MONTH DAY YEAR P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>8/8</u> 19 <u>81</u> to <u>1/30</u> 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>1/29</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.											
22b. SIGNATURE					DEGREE					22c. DATE SIGNED	
<u>Jay Weiner MD</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					1/30/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
Jay Weiner MD					1201 R-Adelp Rd Rockville, Md						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION				
BURIAL			FEB. 3, 1982		HOLY CROSS CEMETERY		YENDOW, DELAWARE CO., PA.				
24. FUNERAL DIRECTOR					25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS CHAMBERS FUNERAL HOME RIVERDALE, MD.					FEB 5 1982		<u>Anna J. [Signature]</u>				

MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02294	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM M. O'NEIL										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 20 19 82	
2. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR July 23 1912		6. AGE (IN YEARS) LAST BIRTHDAY 69 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		2c. DATE PRONOUNCED DEAD 1 20 19 82		2d. HOUR 2d M	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14600 Homecrest Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect		12b. KIND OF BUSINESS OR INDUSTRY Architecture			
13a. STATE Md		13b. COUNTY Mont.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 14600 Homecrest Road			
14. FATHER'S NAME FIRST MIDDLE LAST John Hamilton O'Neil						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Clara Kinney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 11 577- 12-0550		17. INFORMANT ADDRESS Bethe sda, Md. Sara P.O Neill Manion 7711 Radner Rd., B					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Diabetes mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-21-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/23/1982		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland			
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.						25a. DATE REC'D. BY REGISTRAR JAN 25 1982					

July 13 1962

xx

New York

Architectural

1400 Somerset Road

Silver Spring

Mont.

James  
Oline  
Kinney  
Jesse, Jr.  
John, Jr.

James

O'Neil

John Hamilton

Sam P. O'Neil Hamilton 7711 Madison Ave., N.Y.C.

577-12-0550

Yes NW 12

Joseph Gawler's Sons Inc.  
7130 Mac. Ave., N.Y.C.  
1/23/1962 Date of Heaven Cemetery Silver Spring Maryland

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Betty D. Orrison</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>7</b> YEAR <b>82</b>		2b. HOUR <b>12:36A</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>5</b> DAY <b>25</b> YEAR <b>1924</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8. IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>	
9a. BIRTHPLACE STATE OR FOREIGN COUNTRY <b>Maryland</b>		9b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bkpr. Mail Advertising</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spr.</b>	
14. FATHER'S NAME FIRST <b>Paul</b> MIDDLE <b>Bouis</b> LAST <b>Bouis</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Edna</b> MIDDLE <b>Stevens</b> LAST <b>Stevens</b>		16. SOCIAL SECURITY NO. <b>5728</b>	
17. INFORMANT <b>Joseph B. Orrison</b>		18. ADDRESS <b>1911 Marymont Rd. Sil. Spr., Md.</b>		19. DATE OF OPERATION <b>1/9/82</b>	
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		22. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
23. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		24. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		25. LOCATION STREET CITY OR TOWN COUNTY STATE	
26. I certify that (I) (this hospital) attended the deceased from <b>1/7</b> 19 <b>82</b> to <b>1/7</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/6</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		27. SIGNATURE <b>Daniel Goldberg</b>		28. DATE SIGNED <b>1/7/82</b>	
29. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>		30. ADDRESS <b>10401 Old Georgetown Rd Bethesda, Md.</b>		31. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>	
32. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		33. DATE <b>1/9/82</b>		34. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	
35. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		36. ADDRESS <b>Sil. Spr., Md.</b>		37. REGISTRAR'S SIGNATURE <b>Phineas Van Kesteren</b>	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ischemic Cardiomyopathy + Cor. Artery Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION <b>1/9/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	

22. I certify that (I) (this hospital) attended the deceased from **1/7** 19 **82** to **1/7** 19 **82**, that (I) (we) last saw the deceased alive on **1/6** 19 **82**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

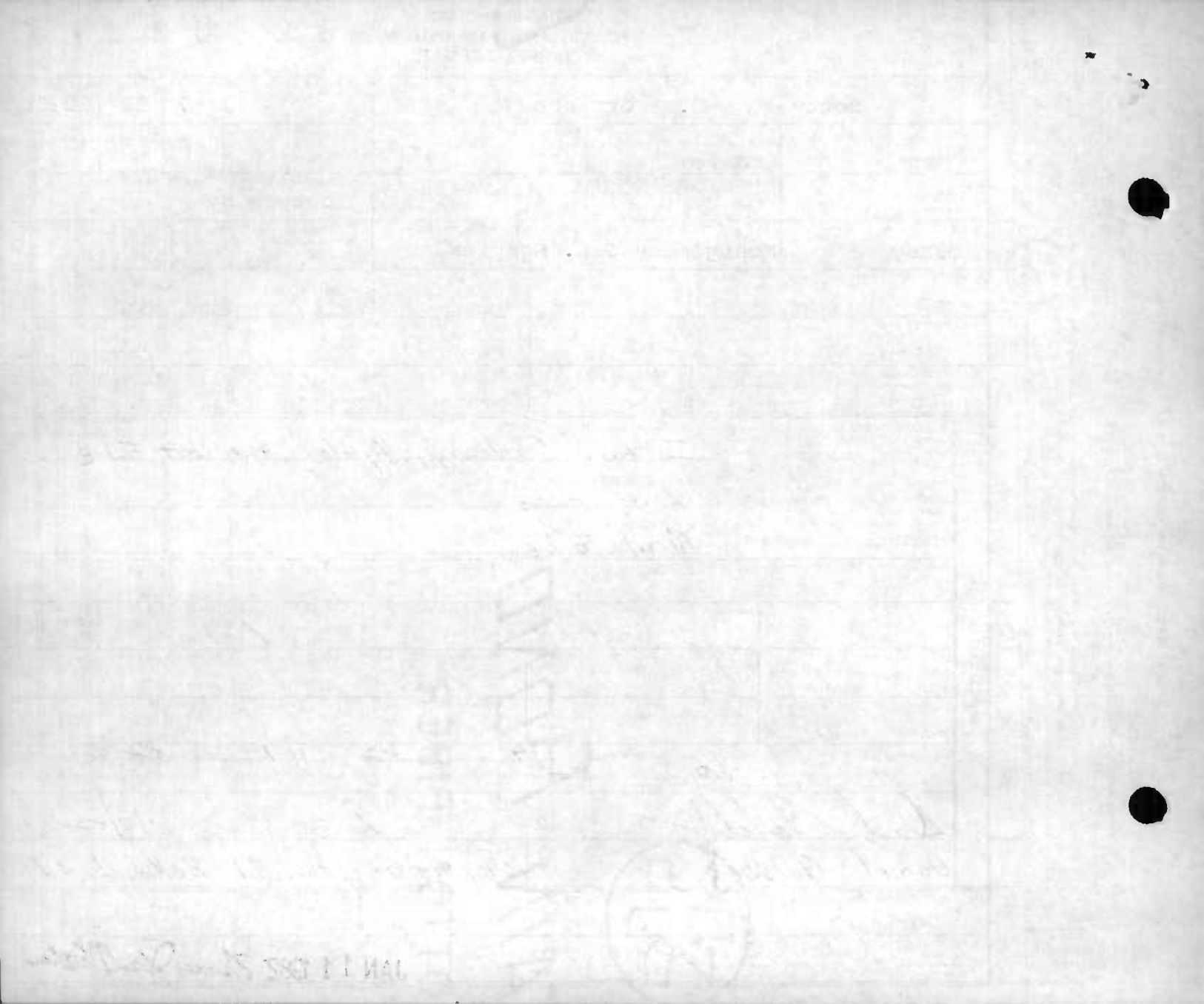
23. SIGNATURE <b>Daniel Goldberg</b>		24. DEGREE <b>MD</b>		25. DATE SIGNED <b>1/7/82</b>	
26. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>		27. ADDRESS <b>10401 Old Georgetown Rd Bethesda, Md.</b>		28. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>	

29. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		30. DATE <b>1/9/82</b>		31. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		32. LOCATION CITY OR TOWN COUNTY STATE <b>Sil. Spr., Md.</b>	
33. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		34. ADDRESS <b>Sil. Spr., Md.</b>		35. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		36. REGISTRAR'S SIGNATURE <b>Phineas Van Kesteren</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 9 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) May G. Orth		2a. DATE OF DEATH MONTH DAY YEAR January 26, 1982		2b. HOUR 4:10 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 1, 1891	
6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9b. CITIZEN OF WHAT COUNTRY? United States		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6222 Stoneham Court		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. STATE Maryland		13b. COUNTY Montgomery	
13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6222 Stoneham Court	
14. FATHER'S NAME FIRST MIDDLE LAST Francis Xavier Goedeke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Henrietta Hartung			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-44-3187		17. INFORMANT ADDRESS Mrs. Nancy O. Venditti, Daughter, Same as item #13	
18. CAUSE OF DEATH (Enter only one cause per line; (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart failure 4140 DUE TO, OR AS A CONSEQUENCE OF: (b) Coronary Arteriosclerotic Heart Disease 12 years. DUE TO, OR AS A CONSEQUENCE OF: (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 19 60 to January 26 19 82, that (I) (we) lost saw the deceased alive on January 12 19 82 and that in my opinion death occurred on the date and hour and from the causes stated here. (If deceased did not view the body after death)					
22b. SIGNATURE J. Blaine Fitzgerald, M.D.		22c. DATE SIGNED January 26, 1982		22d. ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.		22f. ADDRESS 8218 Wisconsin Avenue Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan, 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Parkwood Memorial Park, Baltimore, Maryland	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND			
25a. DATE REC'D. BY REGISTRAR FEB 1 1982		25b. REGISTRAR'S SIGNATURE Name Jan Hartung			

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35  
150  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please preserve retained by the hospital or attending physician.

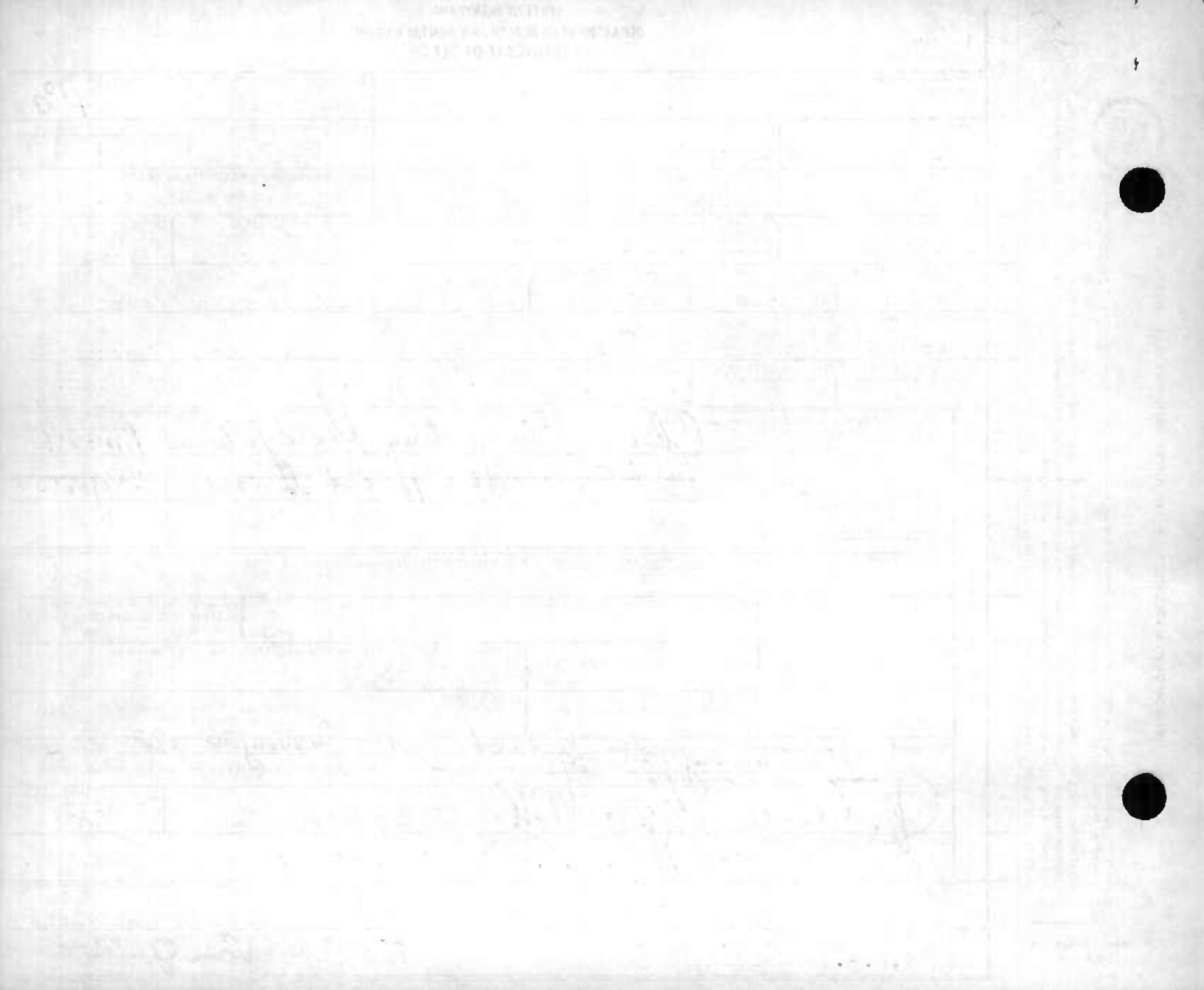
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

29





Items 12a, 12b g564 2/11/82 gj

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 2 9 7

FOR  
1. STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Paul W. Park</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 9 82</b>			2b. HOUR <b>857A</b> M				
3. SEX <b>Male</b>		4. RACE <b>O Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 29 26</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Korea</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Presbyter Baptist minister</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Minister</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5800 Grosvenor Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sung Yong Park</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Chun Sung Soon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT <b>Soon Duk Park</b>		ADDRESS <b>same as 13e</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5715 Coma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hepatic Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Liver Cirrhosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>January 9, 1982</b> to <b>January 9, 1982</b> , that (I) (we) lost saw the deceased alive on <b>January 9, 1982</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Boo K. Kim</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Jan 9, 82</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Boo K. Kim</b>		22e. ADDRESS <b>8921 Shady Grove Court, Gaithersburg, Md 20879</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland</b>						25a. DATE FILED BY REGISTRAR <b>JAN 18 1982</b>				

MEDICAL CERTIFICATION

Cleared by Med Exam.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the health officer within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the health officer within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



W.

Montgomery

X

USA

North

Montgomery

5800 Stevenson Lane

X

Montgomery, Bethesda

Montgomery

Room

Room

Room

Room

Room

Room

Room 300 Park Lane as 1st

570-58-1035

no



Gate of Heaven Cemetery Silver Spring, Md.

1/13/85

Arrival

1331 Rockville Pike Rockville, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 22 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 2 7 3			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary T. Pasquini</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 29, 1982</b>		2b. HOUR <b>2:42 PM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 27, 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>46</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>S.S.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11661 Lockwood Dr. Lockwood</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. INDUSTRY <b>DC Dept. of Human Resources</b>	
13a. STATE <b>Md.</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>S.S.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Shehade</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Shehade</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>None</b>				16b. SOCIAL SECURITY NO. <b>579 46 6979</b>		17. INFORMANT ADDRESS <b>Same as above</b> <b>Lisa Pasquini (Daughter)</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of the lung</b> 1890 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Intestinal obstruction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic carcinoma of the kidney</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-12</b> , 19 <b>81</b> , to <b>1-25</b> , 19 <b>82</b> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <b>1-25</b> , 19 <b>82</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.							
22b. SIGNATURE <b>Dal Yoo, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>Jan. 29, 1982</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>2/1/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Maryland Nat. Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Mont. Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>	
				25b. REGISTRAR'S SIGNATURE <i>Ronald J. North</i>			



*W. C. A.*

*x*

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGES 5, 6, AND 7 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M2/80

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		2 0 2 2 9 9	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH	
Ira Lee Pauley				MONTH DAY YEAR	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7b. HOUR	
M W		MONTH DAY YEAR	LAST BIRTHDAY	M	
		July 1925	58 YRS.	19 82 6 30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. DATE PRONOUNCED DEAD	
Illinois		United States		January 19 82 6 30	
8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
NEVER MARRIED		Montgomery			
WIDOWED					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
Olney		Montgomery General Hosp		(TYPE OF WORK)	
		(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		Sales	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		Mont		Rockville	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		(IF YES, GIVE WAR OR DATES)	
Ira Lee Pauley Sr.		Thelma Hill		351-12-5798	
17. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		17. ADDRESS	
Yes		WW II		Harriet S. Pauley Same as 13c	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) 4291 Acute Myocardial Dis.					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
None				YES NO	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
22a. I certify that I took charge of the remains described above, held on Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Jan. 10, 1982		Metropolitan Crematory Alexandria Va.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Robert A. Humphrey Funeral Homes, P.A., Rockville, Maryland				JAN 18 1982	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	



Handwritten text, possibly a date or a number, located below the circular stamp. It appears to be "10-10-10" or similar, written in a cursive or shorthand style.



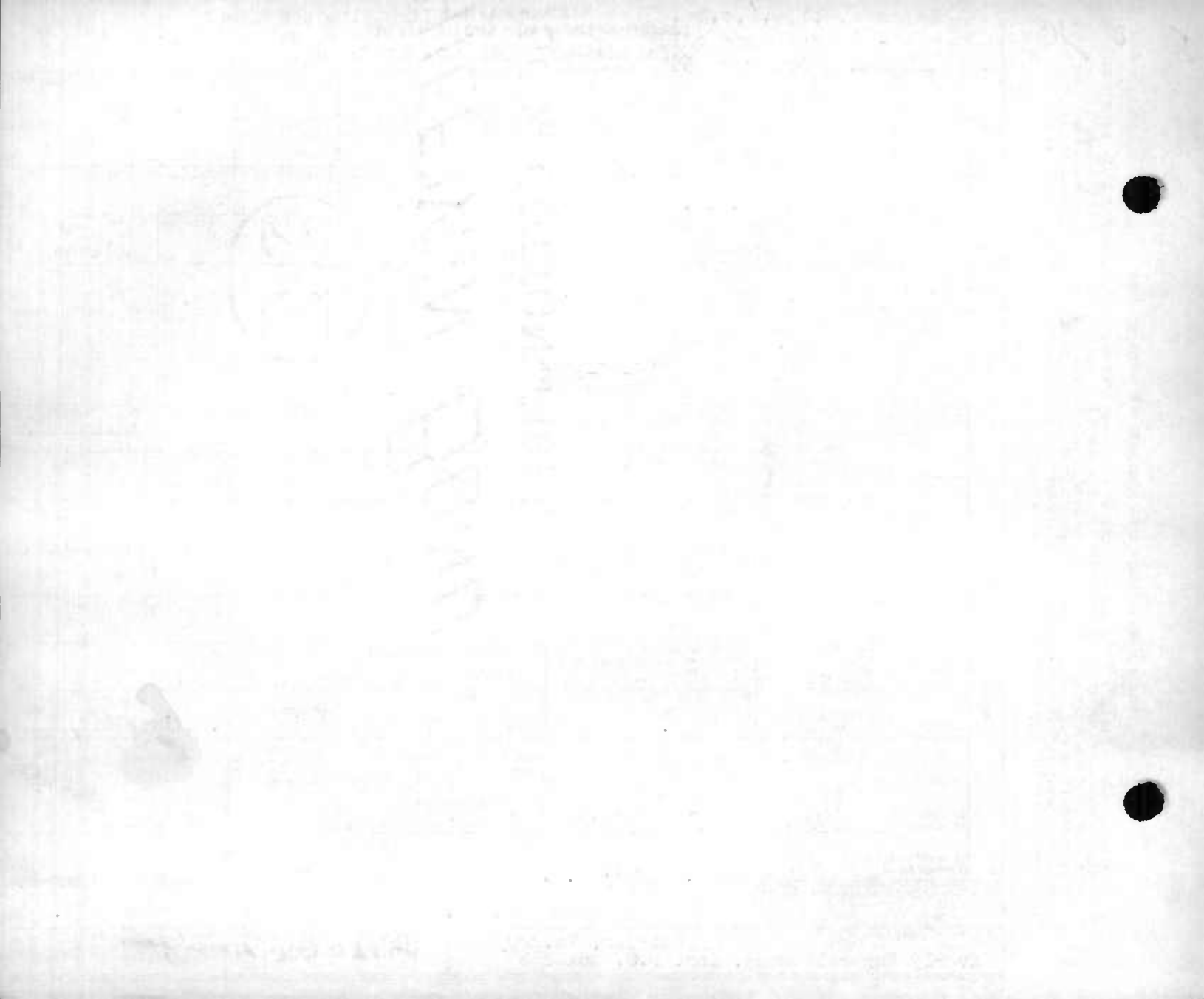


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

1. FOR STATE REGISTRAR		2-5-82 Per Phone call		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		16th per phone call		Jan. 2 3 0 0	
1. DECEASED NAME (TYPE OR PRINT)		CRAIG ROBERT PERSON		2a. DATE KNOWN OF DEATH		1-9-82 19		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.	
male		white		April 8, 1955		26 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. DATE PRONOUNCED DEAD	
Minnesota		U.S.A.				Montgomery County		1-9-82 19	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. DATE	
Silver Springs		University Blvd & Bayfield Street		Student		College		3:28A	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Virginia		Fairfax		Vienna		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3060 Sugar Ln.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Robert A. Person		Sharon Hunstad		No		248-06-2888 225-11-6905		Robert A. Person	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. DATE	
PART I DEATH WAS CAUSED BY:				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		driver of auto/auto head-on collision		1-9-82	
IMMEDIATE CAUSE (a) Multiple injuries									
8120									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22. DATE	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		driver of auto/auto head-on collision		1-9-82	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		3:05AM 1-9-82		driver of auto/auto head-on collision		University Blvd & Bayfield St. Silver Springs, Md.		hgwy.	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
WHITE <input type="checkbox"/> NOT WHITE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		hgwy.		University Blvd & Bayfield St.		Silver Springs, Md.		Fairfax	
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE		Margarita A. Koroll		M.D. Assistant		MEDICAL EXAMINER		1-9-82	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Koroll M.D.		ADDRESS		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. COUNTY	
Burial		1/13/82		Fairfax Mem. Pk.		Fairfax		Fairfax Va.	
24. FUNERAL DIRECTOR		24a. NAME		24b. ADDRESS		24c. DATE REC'D BY REGISTRAR		24d. REGISTRAR'S SIGNATURE	
Everly Funeral Homes, Inc.		Fairfax, Va. 22030		P.O. Box 156		JAN 18 1982			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8202301					
1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur Phillips										2c. DATE ESTIMATED MONTH DAY YEAR 1 15 1982		2d. HOUR MIN 9:05 P.M.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Sept. 9, 1950		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 15 1982		2d. HOUR MIN 9:05 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D. C.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			
10. CITY OR TOWN OF DEATH Takoma Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed				12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE MD		13b. COUNTY MONTG		13c. CITY OR TOWN Silver Spring	
										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 15551 Radwick Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Phillips										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Brunner					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Virginia Hammond (mother) same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to Head (handgun)</u> 9650 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XXXX MONTH DAY YEAR 800 P.M. 1 15 1982				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was shot							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) building				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8502 16th St., Silver Spring, Montgomery Co., Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Virginia L. Dolan</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 1-16-82							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-19-82		23c. NAME OF CEMETERY OR CREMATORY Lincoln Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Montg. Md.					
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850				25a. DATE REC'D. BY REGISTRAR JAN 20 1982							

Rock Column

Left Hand



Right Hand

Top

Bottom

W. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 0 2	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Paul Plass</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1982</b>				2b. HOUR <b>1258</b>		
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 13, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		# UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Photographer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Poolesville</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19628 Fisher Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Martin Plass</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Available</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT <b>Son</b>			ADDRESS <b>4407 Maple Rd. Joseph John Plass Camp Springs, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL HEPATIC FAILURE WITH</b> <b>5728</b> DUE TO, OR AS A CONSEQUENCE OF <b>ENCEPHALOPATHY (COMA)</b> (b) <b>RECURRENT GASTROINTESTINAL TRACT</b> DUE TO, OR AS A CONSEQUENCE OF <b>HEMORRHOIDAL PROBR VARICES</b> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE, RECURRENT BRONCHITIS</b>											
19a. DATE OF OPERATION <b>NA</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1</b> , 19 <b>81</b> , to <b>Jan 10</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Asuncion, Hector</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>January 11, 1982</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Asuncion, Hector</b>					22e. ADDRESS <b>19601 Fisher Ave. Poolesville, MD 20837</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Jan. 12, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>			
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>			25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8202303							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>POLLICH GEORGE - POLLICH</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 10 82</b>			2b. HOUR <b>1855</b> M	
3 SEX <b>M</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>77</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Yugoslavia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Arterial ST</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>10508 Ferrocpe</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10508 Cambridge CT</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Georg - Pollich</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria - Brunner</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		17. INFORMANT ADDRESS <b>Maria M. Pollich 10508 Cambridge Ct. Gaithersburg, Md. 20879</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ventricular arrhythmia</b> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <b>atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>chronic brain syndrome - uning tract infection</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 80</b> to <b>1/10</b> 19 <b>82</b> , that (I) (we) lost the deceased alive on <b>1/10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John R. Melnich</b> MD					DEGREE		22c. DATE SIGNED <b>1/10/82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Melnich MD</b>					22e. ADDRESS <b>16220 Frederick Road, Gaithersburg, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gardner Sanderson</b> 316 E. Diamond Ave., Gaithersburg, Md.					25a. RECEIVED & RECORDED JAN 18 1982 REGISTRAR'S SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				82 02304			
1. STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) <b>LINDEN C PRATO</b>				2a DATE OF DEATH MONTH DAY YEAR <b>1 12 82</b> 2b HOUR <b>1 06 A</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 27 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>	
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Claims Reviewer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5851 Potomac Ave N.W.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Henry Prato</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Bessie Lind Cook</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-60-0089</b>		17 INFORMANT ADDRESS <b>Julia D Prato. Same as item 13.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (the hospital) attended the deceased from <b>1180</b> 19 <b>82</b> to <b>1/11</b> 19 <b>82</b> , that (I/we) last saw the deceased alive on <b>1/11</b> 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE <b>Gary P. Fisher</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary P. Fisher, M.D.</b>		22e. ADDRESS <b>5530 Wisc. Ave., Chevy Chase, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/15/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>	
24 FUNERAL DIRECTOR NAME <b>Joseph Lawler's Sons Inc.</b> <b>5130 Wisconsin Ave., N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 18 1982 Frances Jan Nathan</b>			

MEDICAL CERTIFICATION

Released by Medical Examiner

Male	White	May 27 1899	82
U.S.A.	U.S.A.	XX	
D.C.	Washington	7521 Potomac Ave N.W.	U.S. Gov't.
Unknown	Unknown	Elizabeth	Cook
No	77-20-0089	Smith D. Photo. Same as item 13.	

Gary F. Fisher, N.D.  
 7530 Mac. Ave., Chevy Chase, Md.  
 7521 Potomac Ave., N.W., Washington D.C.  
 7521 Potomac Ave., N.W., Washington D.C.  
 7521 Potomac Ave., N.W., Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 0 5			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothy D Prichard</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 26 '82</b> 2b. HOUR <b>7 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 22 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>64</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife Own Home</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John J. Boland</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Geneva D. Smallwood</b>		13e. STREET ADDRESS <b>2017 Hanover Street</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-46-4242</b>		17. INFORMANT ADDRESS <b>Roger W. Prichard Sil. Spr., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> <b>5713</b> Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause last. (b) <b>ALCOHOLIC LIVER DISEASE</b> (c) <b>CHRONIC ALCOHOLISM</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>UNKNOWN</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>HYPERKALEMIA, UPPER GASTROINTESTINAL BLEED</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 1/26</b> 19 <b>82</b> , to <b>1/26</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arnold G. Levy MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/27/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARNOLD G. LEVY, MD</b>				22e. ADDRESS <b>1106 SPRING ST, SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/30/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem. Silver Spring, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Howard B. Hale</b>		ADDRESS <b>P. O. Box 7428</b>		DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>		REGISTRAR'S SIGNATURE <b>Thom J. Weather</b>	
25. FUNERAL HOME NAME <b>Warner E. Pumphrey, Inc., Sil. Spr., Md.</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Pages 3 and 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. 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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 0 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
Cecilia				1 28 82 5 42 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		WHITE		DECEMBER 18, 1893		88	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
POLAND		U.S.A.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		SEAMSTRESS		UPHOLSTERY	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
MARYLAND				MONTGOMERY		ROCKVILLE	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
ABRAHAM				JUDITH NUSSBAUM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				579-12-2697A		3221 UNIVERSITY BLVD. W MRS. BETTY P. PIKE, KENSINGTON, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardiac arrest							
4292 DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure							
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
				P.M. 19			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/25/82, 1982, to 1/28, 1982, that (I) (we) last saw the deceased alive on 1/27, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Samuel P. Goldberg				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Samuel P. Goldberg				11125 Rockville Pike, Rockville, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL				1/29/1982		MOUNT LEBANON CEMETERY	
23d. LOCATION				23e. DATE RECEIVED BY REGISTRAR		23f. SIGNATURE	
ADELPHI, PRINCE GEORGES, MD.				FEB 1 1982		[Signature]	
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 74 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 0 7			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>First</b> <i>Ted</i> <b>Middle</b> <i>M</i> <b>Last</b> <i>Ralph</i>				2a. DATE OF DEATH MONTH <i>1</i> DAY <i>19</i> YEAR <i>82</i>		2b. HOUR <i>11:45</i> AM	
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>9</i> DAY <i>26</i> YEAR <i>1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <i>New York</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Gen. manager</i>		12b. KIND OF BUSINESS OR FIRM <i>Sperry-Rand Corp.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i> COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Wash., DC</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>2801 New Mexico Ave., N.W.</i>	
14. FATHER'S NAME <b>First</b> <i>Charles</i> <b>Middle</b> <i>R.</i> <b>Last</b> <i>Ralph</i>				15. MOTHER'S MAIDEN NAME <b>First</b> <i>Florence</i> <b>Middle</b> <i>A.</i> <b>Last</b> <i>Hinman</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>578-05-5876</i>		17. INFORMANT ADDRESS <i>Mrs. Harriet A. Ralph-wife - (same as 13e)</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular accident</i> <i>1990</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Carcinomatosis</i> (c) <i>Diabetes Mellitus</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>15 yrs.</i> <i>5 yrs.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Arteriosclerotic Heart disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John E. Everett md</i>				DEGREE		22c. DATE SIGNED <i>1/19/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN E. EVERETT</i>				22e. ADDRESS <i>9400 Conn. Ave Kensington Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>Jan. 20, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematory</i>		23d. LOCATION CITY OR TOWN <i>Washington, DC</i> COUNTY STATE	
24. FUNERAL DIRECTOR <i>Hines/Rinaldi Fun eral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 21 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Nathan</i>	
ADDRESS <i>11800 N.H. Ave., S. S. Md.</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Joseph C. Razza, Sr.</b>					REG. NO. <b>8 2 0 2 5 0 8</b>				
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph C. Razza, SR</b>					2a. DATE OF DEATH MONTH <b>1</b> DAY <b>14</b> YEAR <b>82</b> 2b. HOUR <b>9:25</b> <b>P.M.</b>				
3 SEX <b>Male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>Sept</b> DAY <b>13</b> YEAR <b>1906</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Architect</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>York &amp; Sawyer</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7710 Westfield Drive</b>	
14. FATHER'S NAME FIRST <b>Frank</b> MIDDLE LAST <b>Razza</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Giovanna</b> MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Bethesda, Md. 20817</b> <b>Joseph C. Razza, Jr. -son 7710 Westfield Dr.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardioresp. Arrest</b> <b>1539</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Renal failure</b> (c) <b>Cancer of Colon</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>a</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> to <b>11/4/82</b> , that (I) <del>met</del> last saw the deceased alive on <b>11/4/82</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.									
22b. SIGNATURE <b>Carol L Bender, MD</b> DEGREE <b>MD</b>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Carol L. Bender</b>						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Jan 5, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY <b>20002</b> STATE		
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 11 1982</b> REGISTRAR'S SIGNATURE <b>Jessie San Martin</b>			

Joseph J. Rizzo, Jr.

1970

1970

White

13,100

New York

Montgomery

Bedford

7700 Bedford Drive

Gloversville

Bedford

Bedford

Bedford, N.Y. 11717

Joseph J. Rizzo, Jr. - 7700 Bedford Drive, Bedford, N.Y. 11717

Home

Home

02-07-77

Joseph J. Rizzo, Jr.

Jan 2, 1982

Bedford, N.Y. 11717

Bedford

Bedford, N.Y. 11717

Bedford, N.Y. 11717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 0 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Florence E. Reed</b> <b>FLORENCE E. REED</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>01-19-1982</b>		2b. HOUR <b>10 25 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 24 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ill.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) <b>Bethesda Retirement &amp; Nursing Cen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5420 Conn. Ave., N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Evans</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Kerstetter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-60-2422</b>		17. INFORMANT ADDRESS <b>Susan K. Reed 7511 Springlake Dr., Beth. Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Bilateral</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <b>1/19/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 1 19 76</b> to <b>Jan 19 82</b> , that (I) (we) last saw the deceased alive on <b>Jan 17 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Paul Chang</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-19-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PAUL P.L. CHANG M.D.</b>				22e. ADDRESS <b>2121 Pennsylvania Ave N.W. Washington DC 20037</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/21/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash., D. C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>			

Reference

White

V.S.A.

Montgomery

Cherry Chase Bethesda Retirement Community, Inc.

Washington

2420 Conn. Ave., N.W.

William Vance Florence Kensington

270-00-2552

Quinn A. Reed 7711 Springdale Dr., Falls M.

Greenston

Joseph L. Wier's sons Inc.

2110 Inc. Ave., N.E., Wash., D.C.

Cedar Hill Community Settlement Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>Mary Cush Reese</b>			2a. DATE OF DEATH <b>Jan. 11 '82</b>			2b. HOUR a. <b>3:15 M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>15</b> YEAR <b>'94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>15</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>R.N.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Gaithersburg</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9701 Fields Rd., Gaithersburg,</b>		
14. FATHER'S NAME FIRST <b>David</b> MIDDLE <b>-</b> LAST <b>Richards</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Catherine</b> MIDDLE <b>-</b> LAST <b>Steirch</b>			16. ADDRESS <b>10321 Lloyd Rd., Potomac, Md. 20854</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1918-1919</b>		17. INFORMANT <b>Mrs. Elizabeth Rudisill</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE Cerebrovascular Accident</b> DOE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebrovascular Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN</b> <b>6 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASPIRATION PNEUMONIA</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>11/4</b>		CITY OR TOWN <b>11/11</b>		STATE <b>82</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Roger Stevenson Jr</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/11/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROGER STEVENSON, JR</b>			22e. ADDRESS <b>11125 ROCKVILLE PIKE ROCKVILLE, MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Vestal Hills Mem.Pk.</b>		23d. LOCATION CITY OR TOWN <b>Vestal</b>		COUNTY <b>Broome</b>	STATE <b>N.Y.</b>
24. FUNERAL DIRECTOR NAME <b>Barber Mem. Home, Inc.</b>			428 Main Street, <b>Johnson City, N.Y. 13790</b>			JAN 18 1982			



WOOD WILKINSON

HEALTH NOTIFICATION

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK RUDOLPH REUTIMAN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 17, 1982</b>		2b. HOUR <b>6:45 a.m.</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 8, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MINNESOTA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VIRGINIA</b> 13b. COUNTY <b>FAIRFAX</b> 13c. CITY OR TOWN <b>FAIRFAX</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>12436 LEE HIGHWAY FAIRFAX, VIRGINIA 22030</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK JOHN REUTIMAN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>OTELLA HARRIET BLOOMER</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1941-1968</b>		17. INFORMANT <b>LUCILLE REUTIMAN: FAIRFAX, VIRGINIA 22030</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF LUNG</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>27 DECEMBER 1981</b> to <b>17 JANUARY 1982</b> , that (I) (we) last saw the deceased alive on <b>17 JANUARY 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>K. Karvelis LTMC</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>18 JAN 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. KARVELIS, LT, MC, USNR</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 20, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Arlington Funeral Home</b> ADDRESS <b>3901 N. Fairfax Dr. Arl., Va.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP

RECEIVED  
JAN 19 1941  
U.S. DEPT. OF AGRICULTURE

MAILED  
JAN 19 1941  
U.S. DEPT. OF AGRICULTURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 1 2			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Ariel Pinchus Reutlinger				January 19, 1982 9:30A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		September 20, 1967		14 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.				Montgomery County, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		11216 Bybee Street		Student			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13e. STREET ADDRESS			
Shlomo Reutlinger		Blossom Zlotnick		11216 Bybee Street			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
No		N/A		Blossom Reutlinger 11216 Bybee Street, SS, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Glioblastoma Multiforme 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 Months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from August 27, 1981, to January 19, 1982, that (I) (we) last saw the deceased alive on December 31, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Albert E. Rolle, M.D.						Jan. 19, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Albert E. Rolle, M.D.		1140 Varnum Street, Washington, D.C.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
REMOVAL		1/20/1982		SHOMREI HADAS CHAPEL		4511 FORT HAMILTON PARKWAY BROOKLYN, NEW YORK	
24. FUNERAL HOME		24b. DATE RECEIVED BY REGISTRAR		24c. REGISTRAR'S SIGNATURE			
M. STEIN HEBREW MEMORIAL FUNERAL HOME		JAN 25 1982		Name Jan 25 1982			
232 CARROLL STREET, N.W., WASHINGTON, D.C.							



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 1 3					
1. FOR STATE REGISTRAR			REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH		DAY		YEAR		2b. HOUR			
Eloise S. Richardson			Jan. 22, 1982		12:25						p.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
female		white		Nov. 5, 1896		85		YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		USA				Montgomery County						MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda		Bethesda, 5215 Cedar Lane, Beth.		Carriage Hill		retired school teacher									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Maryland		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input type="checkbox"/>		4710 Morgan Drive							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME											
Anthony A. Shafer				Cora P.											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
no				213-40-7439		Mrs. Ewing same as item 11									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) 1890 Uremia															
DUE TO, OR AS A CONSEQUENCE OF (b) Continued kidney															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
Anterior circulation															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
None		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED											
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION											
WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 19 81, to present 19 82, that (I) (we) last saw the deceased alive on 1/22 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE												DEGREE		22c. DATE SIGNED	
John B. Umshan MD												ATTENDING PHYSICIAN		1/22/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS			
John B. Umshan MD												8805 Cam. Ave. Chevy Chase Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION									
Cremation		1/23/82		Metropolitan Creamery		Alexandria, Virginia									
24. FUNERAL DIRECTOR												24b. ADDRESS			
Wheeler Funeral Home, Inc.												1331 Rockville Pike Rockville, Maryland			

1351 Rockville Pike Rockville, Maryland  
James Wheeler Funeral Home, Inc.  
Metropolitan Cemetery Alexandria, Virginia

NOTED  
JAN 24 1962

no 21 219-40-7439 Mrs. Elaine Anne ne Rose J.

Anthony A. Shafer  
Montgomery Chevy Chase X  
4310 Korman Drive  
F.

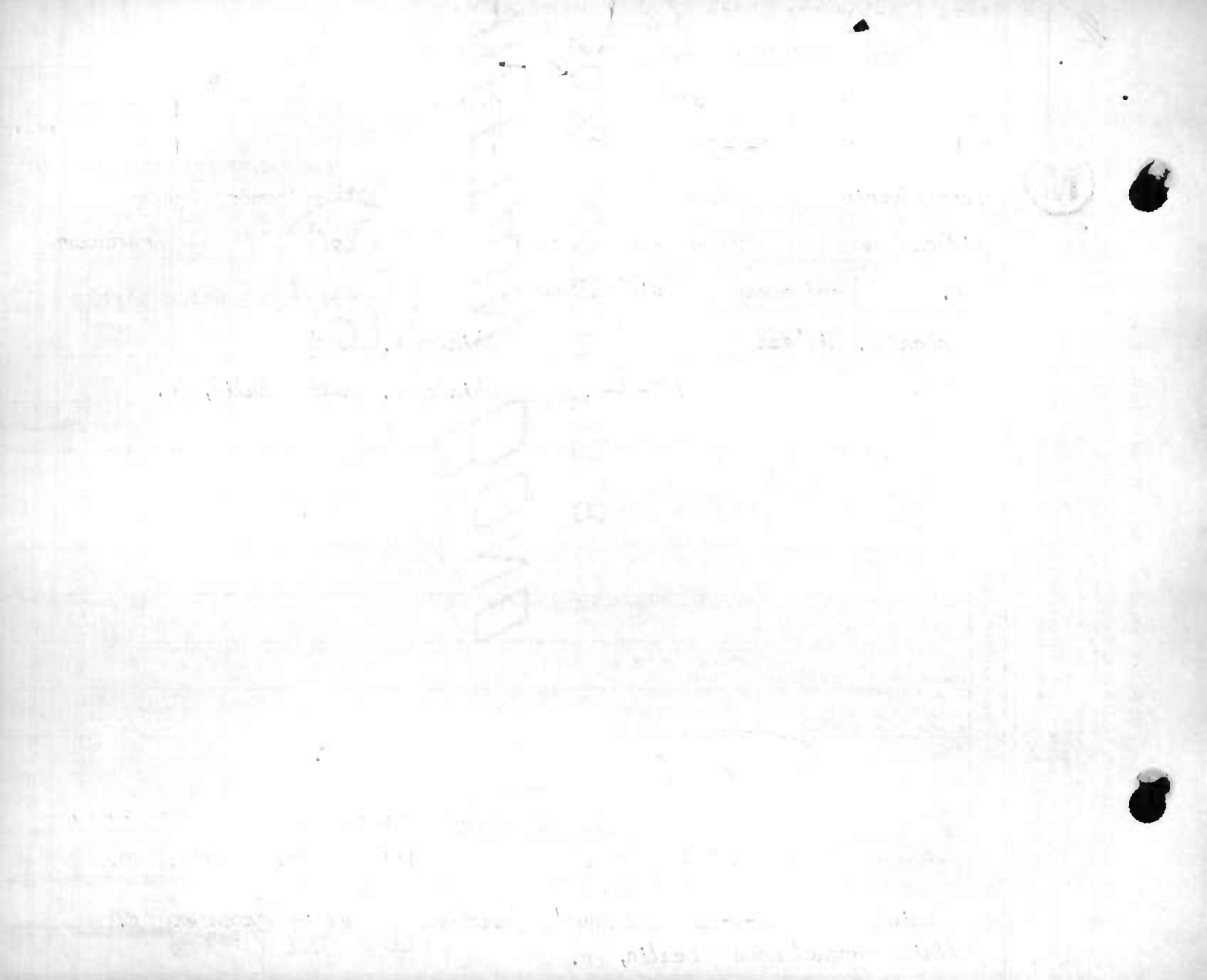
New York  
white  
Rev. J. 1962  
F.

Jan. 22, 1962 12:52



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items 13a-13e per phone 2/8/82		STATE OF MARYLAND		2 0 2 3 1 4	
FOR dad		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		REG. NO.	
1. STATE REGISTRAR		MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH	
Jay Frank Richter				MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
Pennsylvania		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Gaithersburg		Shady Grove Hospital		Chef	
13a. STATE		13b. COUNTY		13c. STREET ADDRESS	
Md.		Montgomery		18417 Lost Knife Circle	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Robert F. Richter		Shirley F. Bruch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		187-44-9137		Shirley F. Bruch Berlin, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
3049 IMMEDIATE CAUSE (a) Narcotism					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Thomas D. Smith, M.D.		Deputy Chief		1/30/82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Thomas D. Smith, M.D.		111 Penn St.		Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2-4-82		St Paul's Churchyard	
24. FUNERAL DIRECTOR		25a. DATE REGD. BY REGISTRAR		25b. LOCATION CITY OR TOWN COUNTY STATE	
Ulrich Funeral Home		FEB 5 1982		Berlin Washington D.C.	
ADDRESS					
Berlin, Md.					





FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 1 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>C'ELIA</b> <b>RISIK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 5 '82</b>		2b. HOUR <b>5:30</b> AM
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 15 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD	
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME OF GREATER WASH.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>HOMEMAKER</b>	
13a. STATE <b>MD.</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>POTOMAC</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>10224 WINDSOR VIEW DR.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>AARON MERKER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PAULINE HERSHKOWITZ</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>117-36-9761</b>		17. INFORMANT ADDRESS <b>MR. PHILIP RISIK 10224 WINDSOR VIEW</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Possible myocardial Infarction</b>		
DUE TO, OR AS A CONSEQUENCE OF (c) <b>arteriosclerotic heart disease</b>		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/4 82</b> P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>5/29</b> 19 <b>81</b> , to <b>1/4</b> 19 <b>82</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>1/4</b> 19 <b>82</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> did not view the body after death.			
22b. SIGNATURE <b>Kshah</b> DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K.H. SHAH MD</b>		22e. ADDRESS <b>6105 MONTROSE ROAD, ROCKVILLE</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1-7-82</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MT. HEBRON</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>FLUSHING N.Y.</b>
24. FUNERAL DIRECTOR NAME <b>1170 ROCKVILLE PIKE ROCKVILLE</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>	
<b>DANZANSKY-GOLDBERG MEM CHAPEL INC. MD.</b>		<b>James J. Nathan</b>	



1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>PARKER W. RISLER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>01/31/82</b>			2b HOUR <b>10:30a</b>				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan. 28, 1912</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7 UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10 CITY OR TOWN OF DEATH <b>Olney, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Tele.Co.</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Silver Spring</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>15101 Glad Drive</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen</b>			16a ADDRESS <b>Thomas</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-01-3267</b>		17 INFORMANT <b>Virginia Risler Wife Same as 13</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Heart Block + Infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>acute myocardial infarction</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a))										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-31-</b> 19 <b>82</b> to <b>1-31-</b> 19 <b>82</b> , that I (we) last saw the deceased alive on <b>1-31-</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Manejwala</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-31-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.G. Manejwala MD</b>			22e. ADDRESS <b>17904 Georgia ave Olney MD 20854</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Feb. 2, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parblawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>			25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>				
500 University Blvd., W. Silver Spring, Md.										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

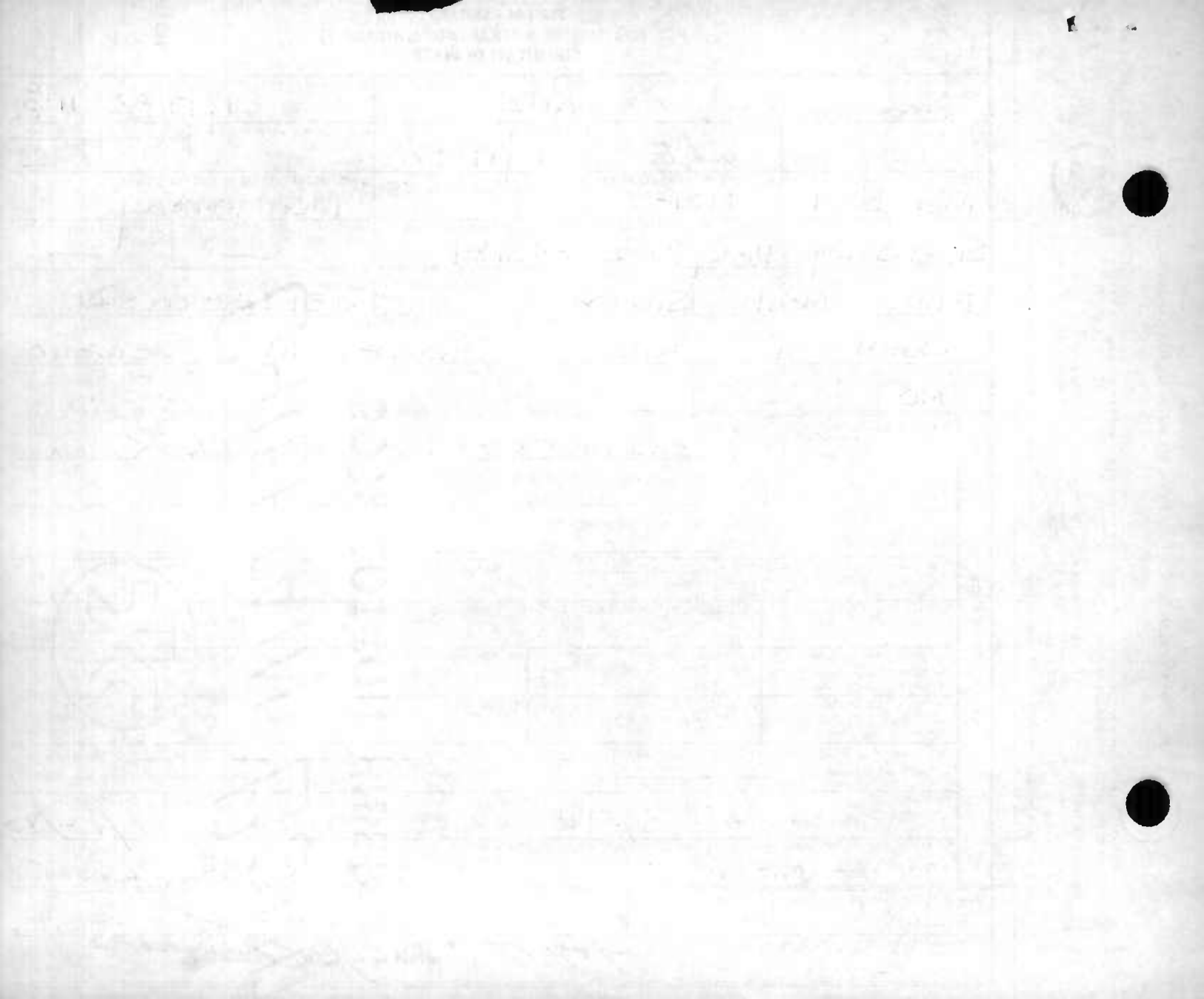
8 2 0 2 3 1 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Infant Boy</b>		LAST <b>Ritz</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1/17/82</b>		2b. HOUR <b>11:18 PM</b>	
3 SEX <b>Boy</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/17/82</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>7/53</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Mary's Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John H. Ritz</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Judith M. Demairo</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>	
17 INFORMANT <b>Judith M. Ritz</b>		ADDRESS <b>431 St. Lawrence Dr.</b>		CITY OR TOWN <b>Silver Spring, Md.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PREMATURITY (24-25 wk. gestation)</b> 7650 DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 1 HR</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>—</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Michael Datch, MD.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/18/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MICHAEL DATCH</b>		22e. ADDRESS <b>10301 GEORGIA AVE SILVER SPRING MD 20902</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 20, 82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Mont. Md.</b>	
24. FUNERAL DIRECTOR <b>Walter E. Pumphrey Inc.</b>		ADDRESS <b>8434 Georgia Ave. Sil. Spr. MD.</b>		25. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 60M 1/75  
(VR A 15 (4))

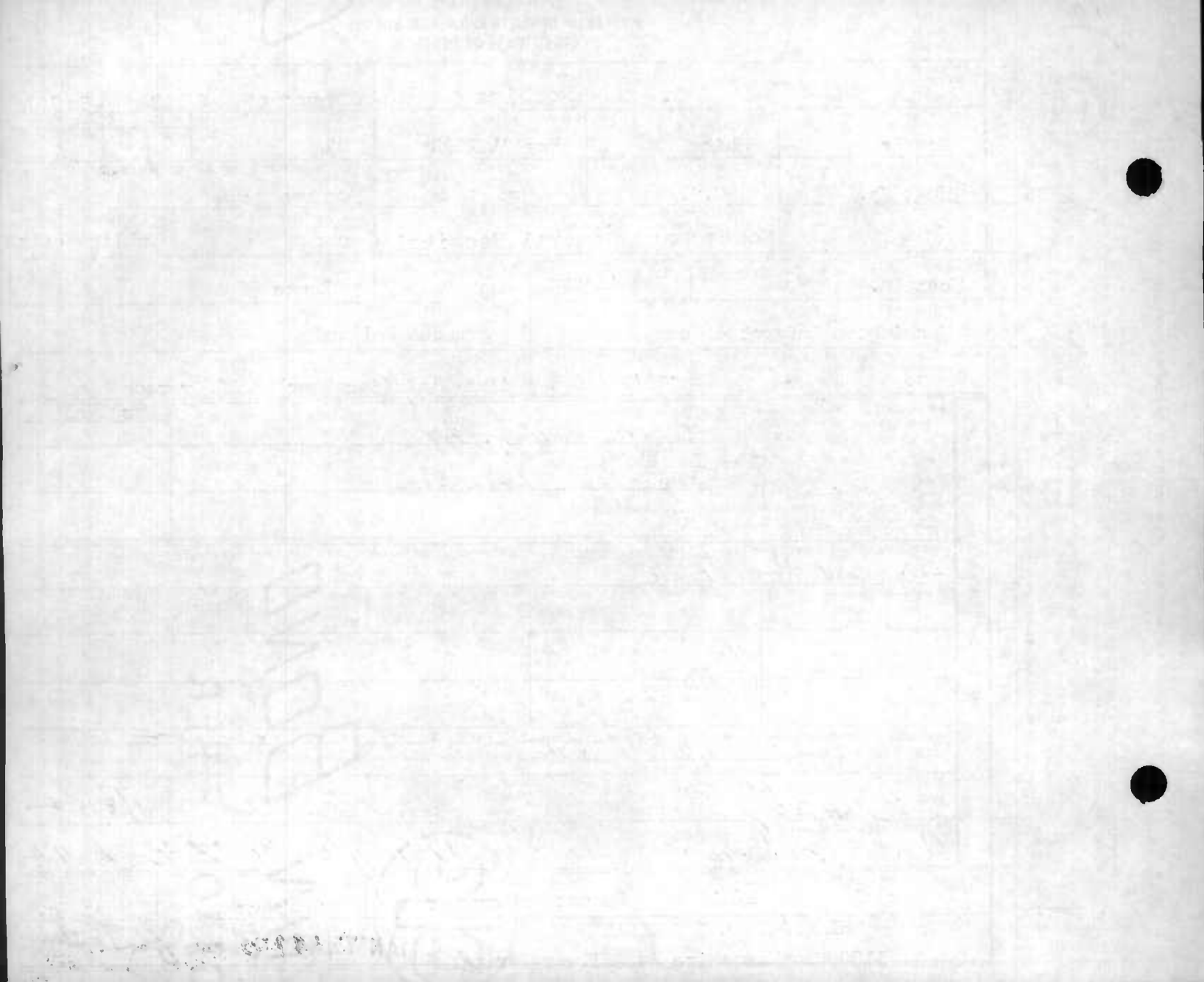
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 1 8

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Nora D. Robbins</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 8, 1982</b>			2b HOUR <b>7:58AM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 21, 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>YRS</b>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Public Health</b>	
13a. STATE <b>West Va.</b>		13b. COUNTY <b>Wood</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>Route #2</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Washington Lafayette Deem</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances Holland</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>233/72/5592</b>		17 INFORMANT ADDRESS <b>Hilma Blair (daughter) 13826 Overton Lane S.S.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ischemic Cardiomyopathy</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Sudden Coronary Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									Maryland
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Liver and Renal Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>81</b> to <b>1/8</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/7</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel Goldberg</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/8/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Goldberg</b>				22e. ADDRESS <b>1040 Old Georgetown Rd Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/11/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memory Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkersburg, Wood, West Va.</b>			
24 FUNERAL DIRECTOR NAME <b>HINES/RINALDI FUNERAL HOME</b> <b>11800 New Hampshire Ave Silver Spring, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 14 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Frances J. [Signature]</b>					

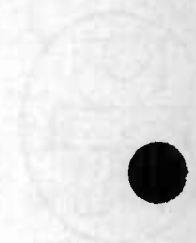


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8 2 0 2 3 1 9									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
EVA B. ROSS								1 12 82		4 30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		March 11 1903		78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN						Supr. Mail Rm			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Sil Spring				306 Lanark Way			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Charles Pindle				Ida Belle Brandt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		577 10 6660A		Wilma R. MacDonald		717 Davidsonville, Md Appomattox Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiop. Arrest</u>											
4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarct</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>12-22-81</u> to <u>1-12-82</u> , that (I) <u>was</u> last saw the deceased alive on <u>1/11</u> 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
Carol L. Bender, MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Carol L. Bender		11510 OLD GEORGETOWN RD. ROCKVILLE, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		16 Jan 1982		Washington National		Suitland Maryland					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E Wilhelm		Funeral Home		JAN 20 1982		[Signature]					
		Suitland Maryland									



SECRET

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 2 3 2 1	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Esther Pauline Rubinstein</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 31, 1982</b>		2b. HOUR <b>1:15 P.M.</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>August 4, 1926</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Colorado</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, Bethesda, Md.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Potomac</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>11017 Seven Hill Lane 20854</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Judah Marcus Fine</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte Sonnenschen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>538-22-4751</b>		17. INFORMANT ADDRESS <b>David Rubinstein (husband) same as patient</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unilateral bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral hemorrhage into site of metastasis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Widely metastatic malignant melanoma</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>month</b> <b>1 month</b> <b>2 1/2 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 11c.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 18, 1981</b> to <b>January 31, 1982</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 31, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.						
22b. SIGNATURE <b>E. Reed, MD</b> DEGREE				22c. DATE SIGNED <b>2/1/82</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie Reed, MD</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garden</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		ADDRESS <b>P.O. Box 7428 Sil. Spr., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b>		

UNITED STATES  
DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, if retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>GERTRUDE BERK SACKS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-3-82</b>		2b. HOUR <b>2 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 7, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HEBREW HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEACHING</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6121 MONTROSE ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MOSES - BERKOWITZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDITH - BERK</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NONE</b>		17. INFORMANT ADDRESS <b>SHELDON SACKS 12101 LILHOW CT. OXON HILL, MD.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrhythmia.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic and Rheumatic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Aortic + Mitral valve replacement.</b>									
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>3/12</b> , 19 <b>76</b> , to <b>1/3</b> , 19 <b>82</b> , that (we) last saw the deceased alive on <b>12/30</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (I) (did not) view the body after death.									
22b. SIGNATURE <b>R. Shah</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>1-3-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. H. SHAH.</b>				22e. ADDRESS <b>6121 MONTROSE ROAD, Rockville</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ISRAEL CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SULLYVAH NEW YORK</b>			
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>				ADDRESS <b>SILVER SPRING, MD.</b>		25a. FILED BY <b>1502</b>			

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CONTRACT DECK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

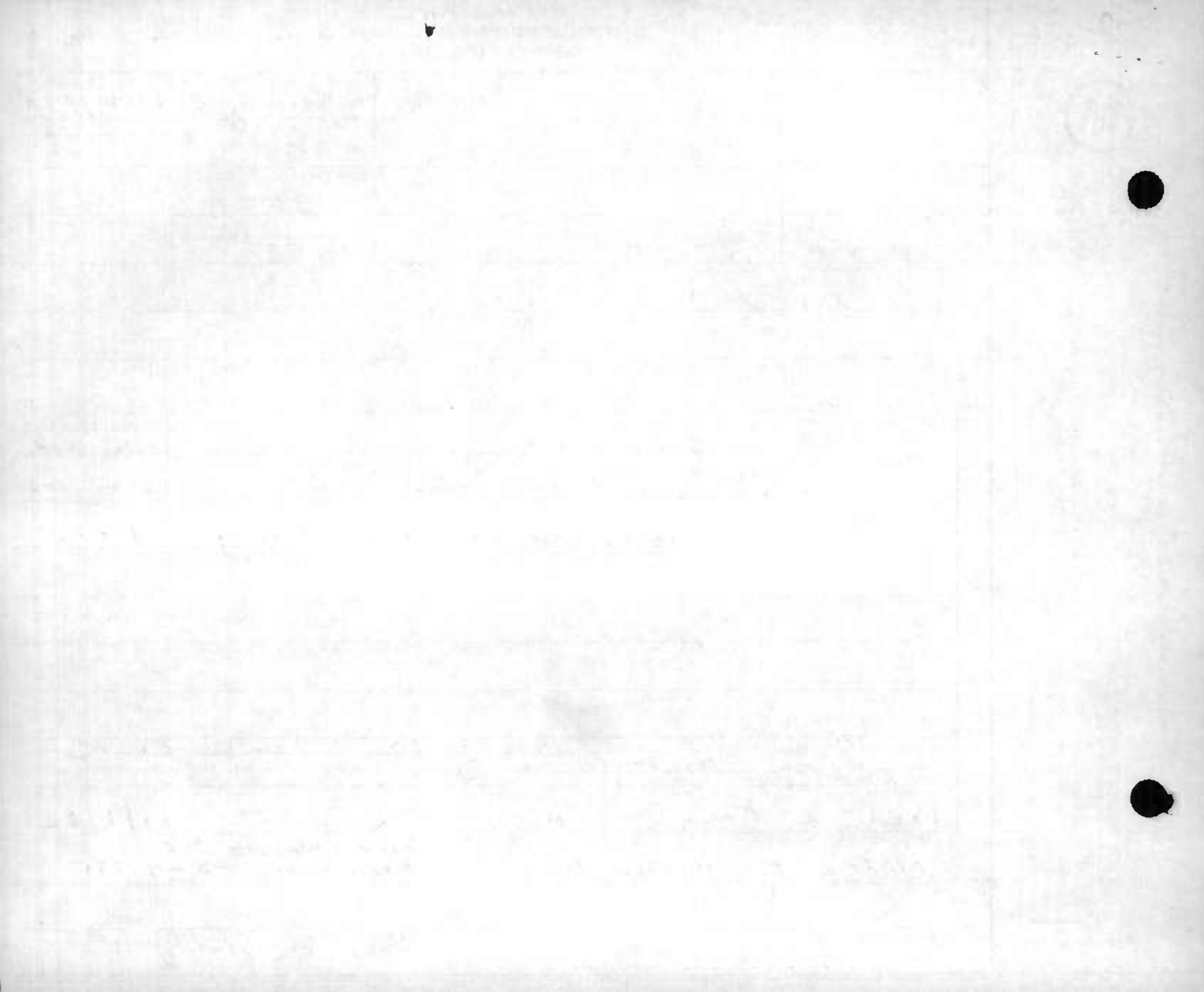
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
ANASTASIA K. SAKELLARIDES						January 8 1982			11:50 AM
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
FEMALE		CAUCASIAN		FEB 9, 1892		89 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
GREECE		GREECE				MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		UNIVERSITY NURSING HOME				HOUSEWIFE			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
MARYLAND			MONTGOMERY		WHEATON		13e. STREET ADDRESS 11306 VIERS MILL ROAD		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
EVANGELOS ATHANASOULIS					PANAGIOTA MOURTIKA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		
NO			578-18-2545		DAUGHTER PAT SAMOS		2612 WELLER ROAD SILVER SPRING, MD.		
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>4379</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SENILE INANITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>CEREBROVASCULAR INSUFFICIENCY</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>6 MONTHS</u> <u>YEARS</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <u>Feb 29, 1980</u> to <u>Jan 8, 1982</u> , that (ii) (we) last saw the deceased alive on <u>Dec 30, 1981</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Martin C. Shargel</u> M.D.					22c. DATE SIGNED <u>1/8/82</u>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARTIN C. SHARGEL M.D.</u>	
22e. ADDRESS <u>3720 FARRAGUT AVE KENSINGTON, MD - 20895</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>1/11/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>SILVER SPRING MONT. MD.</u>		
24 FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>					25a. DATE RECEIVED BY REGISTRAR <u>JAN 13 1982</u>				
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					REGISTRAR'S SIGNATURE <u>Phyllis G.</u>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 8 2 0 2 3 2 4				
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR 1-15-82				2b. HOUR 2:19 PM
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GLADYS H. SANSONE									
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 22 04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D. C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12031 Viers Mill Road	
14. FATHER'S NAME FIRST MIDDLE LAST William Cauldwell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Horworth				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 579 38 8440		17. INFORMANT ADDRESS Paul Sansone (same as # 13)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1749									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 19 54 to January 15, 19 82, that (I) (we) lost saw the deceased alive on January 14, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death.)									
22b. SIGNATURE Aaron H. Traum MD					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED January 15, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AARON H. TRAUM MD					22e. ADDRESS 8915 Georgia Ave Silver Spring Md 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 18, 82		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Md.			
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey INC 8434 GEORGIA Ave. S.S. MD.					25a. DATE REC'D BY REGISTRAR JAN 20 1982		25b. REGISTRAR'S SIGNATURE James J. VanNathan		





*[Faint, mostly illegible handwritten text and markings, possibly bleed-through from the reverse side of the page.]*

RELEASED TO DR. EVANS BY DR. BAIL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8202325			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Andrew Schell				2a. DATE OF DEATH MONTH DAY YEAR HOUR 1 20 82 5:15AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 15 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ky.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Train. & Info. Spec. U.S. Gov't		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Mont. 13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Arthur Ellsworth Schell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Katherine Schneider			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Frances K. Schell. Same as item 13			
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>unknown causes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease, probable 2 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>fever of unknown origin, 2 years</u>							
19a. DATE OF OPERATION <u>8-1-82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>fever of unknown origin, 2 years</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>March 1976</u> to <u>Jan 19 1982</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <u>J. M. Evans</u>		22c. DATE SIGNED <u>MD</u>				22d. ADDRESS 5480 Wis. Ave. Chevy Chase, Md.	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John M. Evans, M.D.		22f. ADDRESS 5480 Wis. Ave. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/26/1982		23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lexington Ky.	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash/ D.C.				25a. DATE REC'D. BY REGISTRAR JAN 25 1982			

RECEIVED JAN 11 1962

1/26/62 Washington Cemetery

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 2 6			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1-14-82			
1. DECEASED NAME FIRST MIDDLE LAST Harry G. A. Schmidt				2b. HOUR 5:45 M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-09-97		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Post Office		12b. KIND OF BUSINESS OR INDUSTRY Govt.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Sil. Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Schmidt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy E. Paul		13e. STREET ADDRESS 10000 Brunswick Avenue,			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-38-6031M		17. INFORMANT ADDRESS Olivia F. Schmidt-wife- (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c)							
PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerotic Accident							
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINERS)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:00 P.M. 19 81		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION (CITY OR TOWN, COUNTY, STATE)			
22. I certify that (1) this hospital attended the deceased from July 81 to January 14, 19 82, and that (2) (we) (we) lost saw the deceased alive on January 13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) not view the body after death.							
22a. SIGNATURE (Physician)		22b. DEGREE M.D.		22c. DATE SIGNED 1/14/82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Mark H. EIG, M.D.		22f. ADDRESS 9801 Georgia Ave Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-19-1982		23c. NAME OF CEMETERY OR CREMATORY Acacia Pk. Memorial N. Tonawanda		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) N. York	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE JAN 18 1982			

1-19-1935  
1180 2nd St.  
Silver Spring, Md.  
JAN 18 1935

Dear Sir:  
I am writing to you in regard to the matter of the  
rental of the building at 1180 2nd St. Silver Spring, Md.  
which you have been renting to me for the purpose of  
conducting my business.

I am writing to you in regard to the matter of the  
rental of the building at 1180 2nd St. Silver Spring, Md.  
which you have been renting to me for the purpose of  
conducting my business.

Very truly yours,  
George  
Schmidt  
1180 2nd St.  
Silver Spring, Md.  
1935

1180 2nd St.  
Silver Spring, Md.  
1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 2 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mildred NMN Schultz</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>82</b>			2b. HOUR <b>1200</b>					
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>21</b> YEAR <b>06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montg.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>256 Newmark Esplanade</b>			
14. FATHER'S NAME FIRST <b>Jovo</b> MIDDLE <b>-</b> LAST <b>Vujnovich</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Najka</b> MIDDLE <b>-</b> LAST <b>Evasovich</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>209-07-8571</b>		17. INFORMANT <b>256 New Mark Esplanade</b> <b>Thomas Schultz</b> <b>Rockville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis, recurrent</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 days</b> <b>Many years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M.</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>December 17</b> 19 <b>81</b> to <b>January 2</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>January 2</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>James E. Wilson, Jr.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/2/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James E. Wilson, Jr. M.D.</b>				22e. ADDRESS <b>11125 Rockville Pike, Rockville, Md. 20852</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Loretto (R.C.) Cem.</b>				23d. LOCATION CITY OR TOWN <b>Pittsburgh</b> COUNTY <b>Alleghany</b> STATE <b>Pa.</b>			
24. FUNERAL DIRECTOR <b>Gartner Sandison F.H.</b>				316 E. Diamond Ave., <b>Gaithersburg, Md. 20877</b>				25a. DATE BY REGISTRAR <b>JAN 6 1982</b>			

MEDICAL CERTIFICATION

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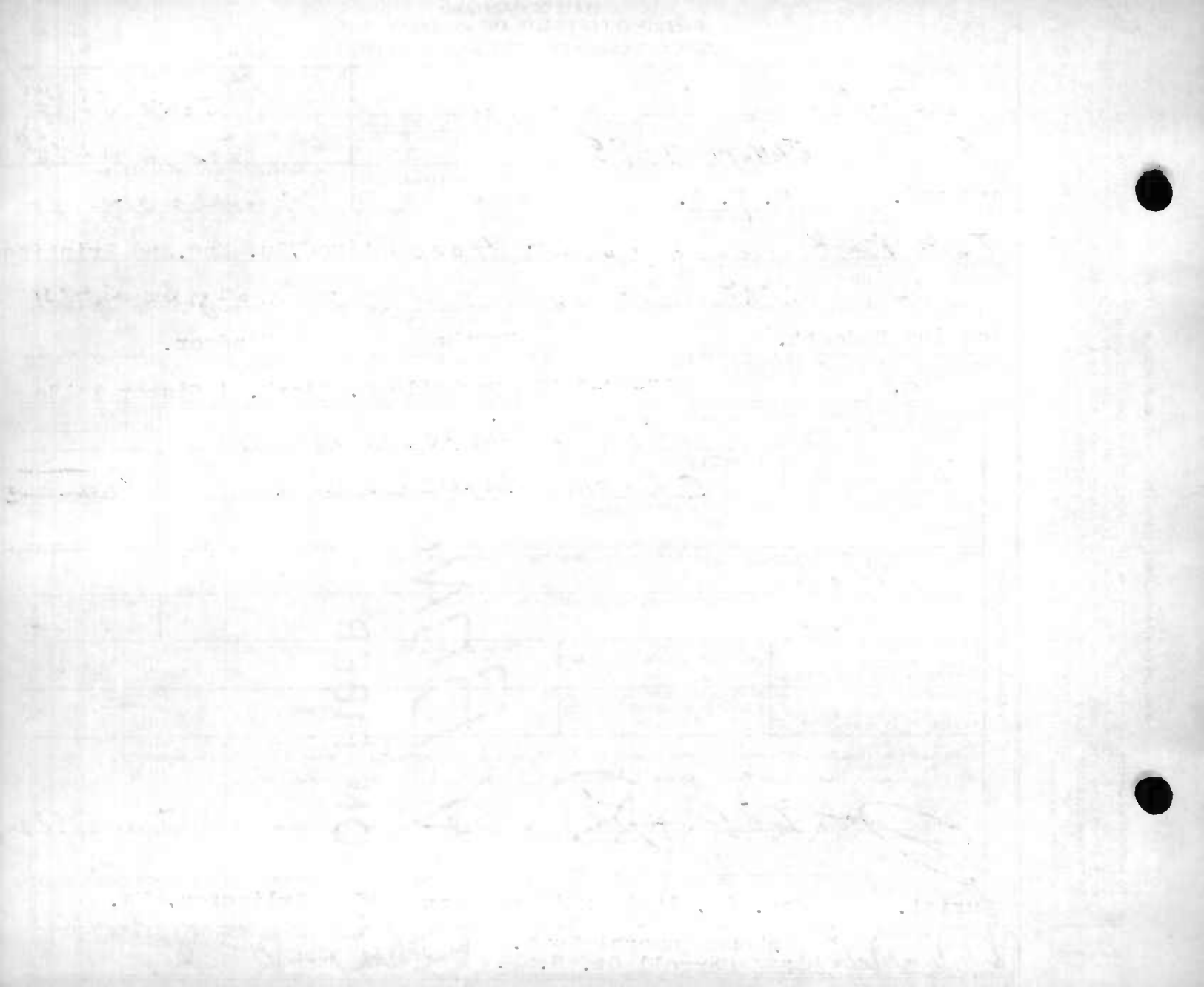
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Subic L. Schultz</i>		2b. DATE KNOWN OF DEATH ESTI-MATED <i>Jan 16 1982</i>		2c. DATE OF DEATH <i>Jan 16 1982</i>		2d. HOUR <i>1240</i>	
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 14 97 88</i>	6. AGE (IN YEARS) MONTHS DAYS HOURS MIN. <i>97 YRS.</i>	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <i>Jan 16 1982</i>		7d. HOUR <i>8</i>	
7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY) <i>Maryland.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>			
10. CITY OR TOWN OF DEATH <i>Tak Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired, Bu. Eng. and Printing</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Pittsburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>7922 Chiswick Ave Apt 801</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Aloysius Padgett.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha Windsor.</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>577-03-3656</i>		17. INFORMANT ADDRESS <i>Maybelle P. Clark. ( Sister ) 13e</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Inf.</i> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Chronic Myocardial Inf.</i> (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Yrs.</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>									
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) <i>M.D.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Jan 16 1982</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>[Signature]</i>				ADDRESS					
23a. BURIAL, CREMATION, REMOVAL <i>Burial.</i>		23b. DATE <i>Jan. 20, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Arlington Va.</i>			
24. FUNERAL DIRECTOR NAME <i>Takoma Funeral Home.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 20 1982</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			
25c. ADDRESS <i>254 Carroll St. N. W.</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 2 9			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		FIRST MIDDLE LAST <b>JAMES D. SECREST</b>		MONTH DAY YEAR <b>JANUARY, 19 1982</b>		HOUR MIN. <b>11 30 A.M.</b>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
<b>Male</b>		<b>White</b>		MONTH DAY YEAR <b>June 30, 1903</b>		YRS. MONTHS DAYS HOURS MIN. <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>Ohio</b>		<b>U.S.A.</b>				<b>MONTGOMERY CO. MD.</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
<b>BETHESDA</b>		<b>SUBURBAN Hospital</b>		<b>Executive</b>		<b>Trade Asso. Electronics</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS			
STATE COUNTY <b>D.C.</b>		<b>Washington</b>		<b>3714 Van Ness St N.W.</b>			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST <b>Harry Secrest</b>		FIRST MIDDLE LAST <b>Anna Lupton</b>		<b>No</b>		<b>577-03-2955</b>	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<b>Richard T Secrest</b>		<b>HYOTENSION AND CARDIAC ARREST</b>		<b>Springfield, Va.</b>			
<b>80001 Rockwood Court,</b>		<b>4149</b>				<b>5 DAYS</b>	
		DUE TO, OR AS A CONSEQUENCE OF					
		(b) <b>CORONARY ARTERY DISEASE</b>					
		DUE TO, OR AS A CONSEQUENCE OF					
		(c)					
		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
		<b>PARKINSON'S DISEASE</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-12</b> , 19 <b>82</b> , to <b>1-19</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1-19</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		<b>Alan Jerry Friedman</b>		<b>M.D.</b>		<b>1-20-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
<b>ALAN JERRY FRIEDMAN</b>		<b>5454 WISCONSIN AVE. CHEV CHNE, MD</b>		<b>Cremation</b>		<b>1/22/82</b>	
				23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
				<b>Cedar Hill Crematory</b>		<b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
<b>Joseph G. Waler's Sons Inc.</b>		<b>JAN 27 1982</b>		<b>James J. Wether</b>			
<b>5130 Wisc. Ave., N.W. Wash., D.C.</b>							

James D. [unclear]

Male White

x

Ohio

11-1-44

Hospital

Executive

11-1-44

Washington

11-1-44

11-1-44

Secret

11-1-44

London

11-1-44

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corpanopans. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items #5,13d&15 Film G563 1/18/82 STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 0 2 3 3 0									
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2b. HOUR				
James W. Seiler					January 2, 1982 10:10 AM				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR	
Male		White		Nov. 21 16		65 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Indiana		USA				Montgomery County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							
Olney		Montgomery General Hospital							
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
12a. STATE 12b. CITY 12c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2200 Ednor Rd.		
14 FATHER'S NAME FIRST MIDDLE LAST					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
James F. Seiler					Laura Scherffius Schoeffius				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS		
Yes					WW11		Mary G. Seiler, Wife. Same as item 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1889 DUE TO OR AS A CONSEQUENCE OF (b) DUE TO OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1. DIFFUSE CARCINOMATOSIS									MONTHS
2. BONE, BRAIN, LUNG METASTASIS									1
3. CARCINOMA BLADDER									1 YEAR
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
			P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/20/81 to 1/2/82, that (I) (we) lost saw the deceased alive on 1/2/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.									
22b. SIGNATURE DEGREE					22c. DATE SIGNED				
Donald R. Lewis MD					1/2/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
DONALD R. LEWIS MD					OLNEY, MARYLAND 20832				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial/Removal			1/5/1982		Oak Hill Cemetery		Evansville Ind		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR SIGNATURE				
Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.					JAN 7 1982 James Jan Nathan				

BP

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George Washington



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 3 1			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1 12 82 2b. HOUR 8 15 A.M.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VICTOR H. SERUNIAN							
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR NOV 4, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRAN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1131 UNIVERSITY BLVD., WEST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RUG BUYER		12b. KIND OF BUSINESS OR INDUSTRY AVAKIAN BROS. IN.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1131 UNIVERSITY BLVD., WEST		14. FATHER'S NAME FIRST MIDDLE LAST HAMPARTZUM SERUNIAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SENAM MOORHATCH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WW 11 241-50-4562		17. INFORMANT BARRY V. SERUNIAN		ADDRESS SAME AS 13 SON	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1985 IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Mitral Stenosis DUE TO, OR AS A CONSEQUENCE OF (c) Cordoma of Sacral Spine				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION 1972		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cordoma of Sacrum/Coccyx		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/3 1982 to 1/13 1982, that (I) (we) last saw the deceased alive on 1/3 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN B. M. M. M. D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARSEN MANGASARIAN		22e. ADDRESS 2010 R St NW.		DC 20009			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/14/82		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR JAN 18 1982		25b. REGISTRAR'S SIGNATURE	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 3 2	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Curtis Glenn Shaw										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR <u>Jan 10 1982</u> 2b. HOUR <u>2215</u> M	
3. SEX Male	4. RACE Cauca.	5. DATE OF BIRTH MONTH DAY YEAR <u>12 13 30</u>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>51</u>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <u>01 10 19 82</u>		2d. HOUR <u>2215</u> M			
7a. BIRTHPLACE (STATE OR TERRITORY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adventist Hosp.</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Vice President Weaver Brothers</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>			
13a. STATE <u>MD</u>		13b. COUNTY <u>Mont</u>		13c. CITY OR TOWN <u>Derwood</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>7316 Muncaster Mill Rd.</u>			
14. FATHER'S NAME FIRST MIDDLE LAST Edward Morrison Shaw					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST F. Marie Kline						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>Korea</u>		17. INFORMANT ADDRESS <u>578-50-9075</u>		17. INFORMANT ADDRESS <u>Helen V. Shaw Wife Same as item 13</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John G. Ball</u>		TITLE (SPECIFY) <u>M.D. Deputy</u>				MEDICAL EXAMINER		DATE SIGNED <u>Jan 11, 1982</u>			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.		7936 Old Georgetown Rd. Bethesda, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>Jan. 14, 1982</u>		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR JAN 21 1982		25b. REGISTRAR'S SIGNATURE <u>Frances Jan Nathan</u>			



Colonial Agricultural Agents  
Cecil Rhodes

John H. B. B.

John H. B. B.

John H. B. B.

John H. B. B.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 3 3

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas P. Shifflett</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>January 1, 1982</b>		2b. HOUR <b>10<sup>02</sup> P M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 19, 1913</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Heavy equipment operator</b>	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>28501 Kempton Rd.</b>			
13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Linwood Shifflett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Belle Gooden</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>225-01-5585</b>		17. INFORMANT ADDRESS <b>Margaret S. Shifflett, Item 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary aneurysm</b> <b>4140</b> DUE TO OR AS A CONSEQUENCE OF (b) <b>Chronic atherosclerotic heart disease &amp; angina</b> DUE TO OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD, Diabetes mellitus, abdominal pain</b>					
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>11/18/82</b> 19 <b>82</b> , to <b>1/1/82</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>11/18/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE <b>John G. L. O'Donnell M.D.</b>	
22c. DATE SIGNED <b>1/1/82</b>		22d. ADDRESS <b>1811 Prince Philip Dr. Olney, MD 20845</b>		22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G. L. O'DONNELL M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 5, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Clarksburg Meth.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Clarksburg, Montg., Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Olin L. Molesworth, P.A., Damascus, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1982</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE BOARD OF DIRECTORS  
OF THE

UNION OF THE

LABORERS

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Jan. 1, 1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Golda SIFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-31-82</b>		2b. HOUR <b>440 P.M.</b>						
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 9 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Govt. Emp. (Ret) US Govt.</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8484 - 16th Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip Margolis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Wolf</b>				16. ADDRESS <b>Arlington, Va.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-03-4117A</b>		17. INFORMANT <b>Morton Blum; 2111 Jefferson Davis</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>5860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myo Cardiac infarction, Pump failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/23/82</b> , 19 <b>82</b> , to <b>1/31/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/30/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Tony P. Kannarkat</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/31/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>TONY P. KANNARKAT</b>				22e. ADDRESS <b>8201 16th St. S.S. MD 20910</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-3-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Adath Yeshurun Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>											

Handwritten notes on lined paper, including dates like 1942, 1943, and 1944, and various illegible entries.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and released by the hospital or attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by [Signature] 1/1/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Anna Silverstein					2a. DATE OF DEATH MONTH DAY YEAR 1.1 .82					2b. HOUR 1220PM
3 SEX female		4. RACE cauc		5. DATE OF BIRTH MONTH DAY YEAR 3 14 1891		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Latvia		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland					13b. CITY OR TOWN Rockville		13c. STREET ADDRESS 10500 Rockville Pike #502			
14. FATHER'S NAME FIRST MIDDLE LAST Simon Mann					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ukn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 146 18 7453		17. INFORMANT ADDRESS Mildred Bonnett (same as #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> 4416 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis</u> Indef. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH < 1 DAY										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1-82</u> 19 <u>82</u> to <u>1-1</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>1-1</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph W. Peabody Jr MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1.1.82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH W. PEABODY JR MD					22e. ADDRESS 1234 19th St, N.W., WASH., D.C. 20036					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 4, 1982		23c. NAME OF CEMETERY OR CREMATORY King David Ceme:		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Va.			
24. FUNERAL DIRECTOR Warner E. Pumphrey			8434 Ga. Ave. ADDRESS			25a. DATE REC'D. BY REGISTRAR JAN 5 1982		25b. REGISTRAR'S SIGNATURE [Signature]		

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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM SIMON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 25, 1982</b>			2b. HOUR <b>1:30 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 8, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9305 Avenel Road</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sale Distributor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		
13a. STATE <b>Md</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>			
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>9305 Avenel Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Simon</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Plotnik</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>053-07-8544</b>		17. INFORMANT ADDRESS <b>Sylvia Simon (Same as # 13)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>METASTATIC COLON CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 6, 1981</b> to <b>Jan 25, 1982</b> , that (I) (we) last saw the deceased alive on <b>Jan 19, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.								22c. DATE SIGNED <b>1/25/82</b>	
22b. SIGNATURE <b>Eugene P. Flannery</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22e. ADDRESS <b>18111 Prince Philip Dr., Olney, Maryland</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene Flannery, M.D.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/27/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Montgomery, Md.</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 29 1982</b>			

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MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 3 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NANNIE L. SIMS			2a. DATE OF DEATH MONTH DAY YEAR 1-22-82		2b. HOUR 0915A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 4 1 94		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY Education
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? X NO <input type="checkbox"/>	13e. STREET ADDRESS 20432 Aspinwood Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Abraham L. Lowry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Freshman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 234-96-3047		17. INFORMANT ADDRESS Myrtle S. Martin Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malignant cystadenocarcinoma</i> 1830 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>1-22-82</u> to <u>1-22-82</u> that (I) (we) last saw the deceased alive on <u>1-22-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>N. H. Bahraini</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1, 22, 82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nasser H. Bahraini		22e. ADDRESS 19231 Montgomery Village Ave. Gaithersburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE January 27 1982	23c. NAME OF CEMETERY OR CREMATORY Lowry Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Springdale, West Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.		ADDRESS Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 27 1982	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-1234.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 3 8			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Tryling L Singer</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>1-25-82</i>			
3 SEX <i>MALE</i>		4 RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-09-09</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>72</i>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>RUSSIA</i>		7b CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10 CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>GROCCER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>PRODUCE DEPT.</i>	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>YAAKOV SINGER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>NISSLE PEARLSTEIN</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>YES WW II</i>		16b. SOCIAL SECURITY NO. <i>477-10-6712</i>		17. INFORMANT ADDRESS <i>HARRIET S. FREDMAN, 11805 MONTICELLO AVE. SILVER SPRING, MARYLAND</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary heart failure</i> 5-188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Chronic lung disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic lung disease</i> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Urinary tract obstruction, Cerebrovascular disease</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 hr</i> <i>10 hr</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>1/25/82</i> to <i>1/25/82</i> , that (I) (we) last saw the deceased alive on <i>1/25/82</i> 19 <i>82</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>Ira N. Tublin M.D.</i>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>1/25/82</i>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>IRA N. TUBLIN, M. D.</i>				22f. ADDRESS <i>8830 CAMERON STREET, SILVER SPRING, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i>		23b. DATE <i>1/27/1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>JUDEAN MEMORIAL GARDENS</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>OLNEY, MONTGOMERY, MARYLAND</i>	
24. FUNERAL HOME NAME ADDRESS <i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</i>				25. DATE REC'D. BY REGISTRAR <i>JAN 29 1982</i>			



March 28, 1914  
To the Honorable Secretary of Agriculture  
Washington, D. C.  
Dear Sir:  
I have the honor to acknowledge the receipt of your letter of the 26th inst. regarding the matter of the proposed extension of the contract for the purchase of the land in the State of Texas, and in reply to inform you that the same has been referred to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours very truly,  
J. H. ...  
Special Agent in Charge

Very truly,  
J. H. ...  
Special Agent in Charge

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

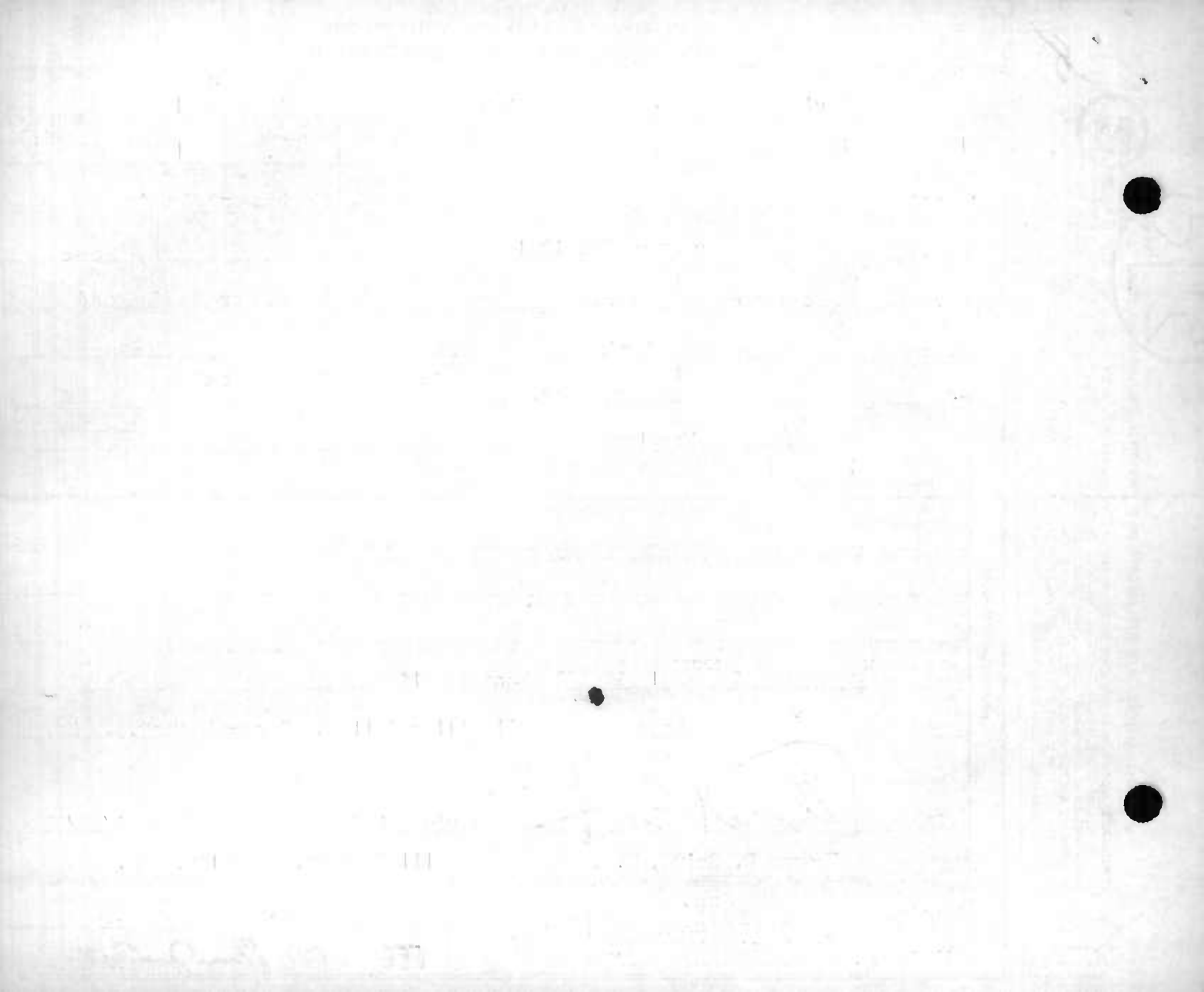
DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH		3. MONTH		4. DAY		5. YEAR		6. HOUR	
Kevin N. Sink		1 25 1982		1		25		1982		6:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	United States			Montgomery County, MD.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Derwood	Shady Grove Hospital	Student		None							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Derwood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7401 Miller Fall Road			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
John Henry Sink		Ann McGary									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		213-88-1826		Mr. John H. Sink, Father,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hanging											
9530											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR XXXX MONTH DAY YEAR P.M. ? XXXX 1 25 1982		Hanged self							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
		home		7401 Miller Fall Rd.		Derwood, Mont.				Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED							
Thomas D. Smith, M.D.		M.D. Deputy Chief		1/26/82							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
		III Penn St.		Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		Jan. 29, 1982		Parklawn Memorial		Rockville, Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND		FEB 1 1982		Name Jan. 1982							

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 4 0	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Louise Sloan</b>							2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <input checked="" type="checkbox"/> Jan. 10 1982		2b. HOUR 10:20 AM		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb 15 16 65</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>65</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>Jan 10, 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>			7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11917 Renwood La.</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>11917 Renwood La.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Sullivan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Phillips</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>060-20-6942</b>		17. INFORMANT ADDRESS <b>Dale F. Sloan Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular + Cardio Valvular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized Arterio Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>MD Perutz</b>				DATE <b>Jan 10, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 13, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Va.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Home P.A., Rockville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>					

Generalization of Axioms 2.4.12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 4 1	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>GENEVA P. Smith</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-23-82</b>		2b. HOUR <b>8:20 P.M.</b>			
3. SEX <b>F</b>		4. RACE <b>B</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-05-37</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food Service Mgr.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>District Heights</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>1977 Rochelle Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Parrott</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>227 44 5802</b>		17. INFORMANT ADDRESS <b>Little Mack Parkway, NY. Mrs. Elizabeth Parrott-sister-3826</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute leukemia</b> <b>2080</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE MONTH</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
19a. DATE OF OPERATION <b>1/23/82</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Acute leukemia</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> , 19 <b>81</b> , to <b>1/23</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/23</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Harvey I. Katz</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/25/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HARVEY I. KATZ MD</b>		22e. ADDRESS <b>6555 Belcrest Rd. Hyattsville MD</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 28, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery-Suitland</b>		23d. LOCATION CITY OR TOWN COUNTY <b>Suitland, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Stewart</b>		24b. ADDRESS <b>Funeral Home-4001 Benning Road, N.E.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

BP

1-23-88

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 4 2							
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>MARJORIE</b>		MIDDLE <b>E</b>		LAST <b>SMITH</b>		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
<i>Marjorie E</i>		<i>Smith</i>						<i>01-19-82</i>								<i>4<sup>07</sup> A.M.</i>	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
<b>Female</b>		<b>White</b>		<b>Oct. 31 1911</b>		<b>70</b>		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
<b>Ill.</b>		<b>U.S.A.</b>				<b>Montgomery County</b> MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
<i>Bethesda</i>		<i>Suburban Hospital</i>		<b>Secretary (Ret)</b>		<b>U.S. Gov't.</b>											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
<b>Md.</b>		<b>Mont.</b>		<b>Bethesda</b>		YES <input type="checkbox"/> NO <input type="checkbox"/>		<b>7605 Maryknoll Ave.</b>									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
<b>Ralph S Smith</b>		<b>Mary Priscilla Fortier</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
<b>No</b>		<b>533-28-1410</b>		<b>William F Smith.</b>		<b>614 S 4th St., Chipley, Va</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 1. DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) <i>Respiratory arrest</i>										<i>3 min.</i>							
4310																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Hemorrhage</i>										<i>9 days</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
		P.M. 19															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION													
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (the hospital) attended the deceased from <i>June</i> , 19 <i>77</i> , to <i>1-19</i> , 19 <i>82</i> , that (I) <del>was</del> lost saw the deceased alive on <i>1-18</i> , 19 <i>82</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED											
<i>John Tauber</i>		<i>M.D.</i>				<i>1-19-82</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
<i>John Tauber</i>		<i>8218 Wisconsin Ave, Bethesda</i>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
<b>Burial</b>		<b>1/22/1982</b>		<b>St. John's Cemetery</b>		<b>Forest Glen, Maryland</b>											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
<b>Joseph Gawler's Sons Inc.</b>		<b>JAN 22 1982</b>		<i>Thomas Jan Nathan</i>													
<b>5130 Wisc. Ave., Wash., D.C.</b>																	

MEMORANDUM

TO : Mr. Tolson  
FROM : Mr. Clegg  
SUBJECT: [illegible]

xx

Re: [illegible]

7005 Maryland Ave.

London

Trinidad

Mary

Smith

Smith

225-28-1410

No

William F. Smith, 614 1/2 St., Chicago, Ill.

1/25/1935  
J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

2130  
J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

JAN 25 1935

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 4 3							
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Mettie		WMN		Smith				JAN 21 82		9		00		A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		(IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		Caucasian		May 7, 1910		71		YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Kentucky		United States				Montgomery County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Takoma Park		Washington Adventist Hosp.		Homemaker		Home											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. COUNTY		13d. CITY OR TOWN		13e. INSIDE CITY LIMITS?		13f. STREET ADDRESS							
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>				12003 Dewey Road							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Henry		Ollie															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS											
No		403-38-8504		Coleman Smith Jr.		11217 Coppermine Woodsboro, Maryland Rd.											
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
2500		Acute Pulmonary Infarct		(b)		Coronary Heart Disease											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)		Diabetes Mellitus													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):		Acute Cellulitis of the															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
C				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from January 19 62 to January 21 82 saw the deceased alive on January 20 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Arthur A. Davis, M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/82									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
Burial		Jan. 25, 1982		Parklawn Mem.		Park Rockville, Montg.		Md.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Robert A. Pumphrey Funeral Homes, P.A.		JAN 27 1982		Frances Jan. Nathan													

BP

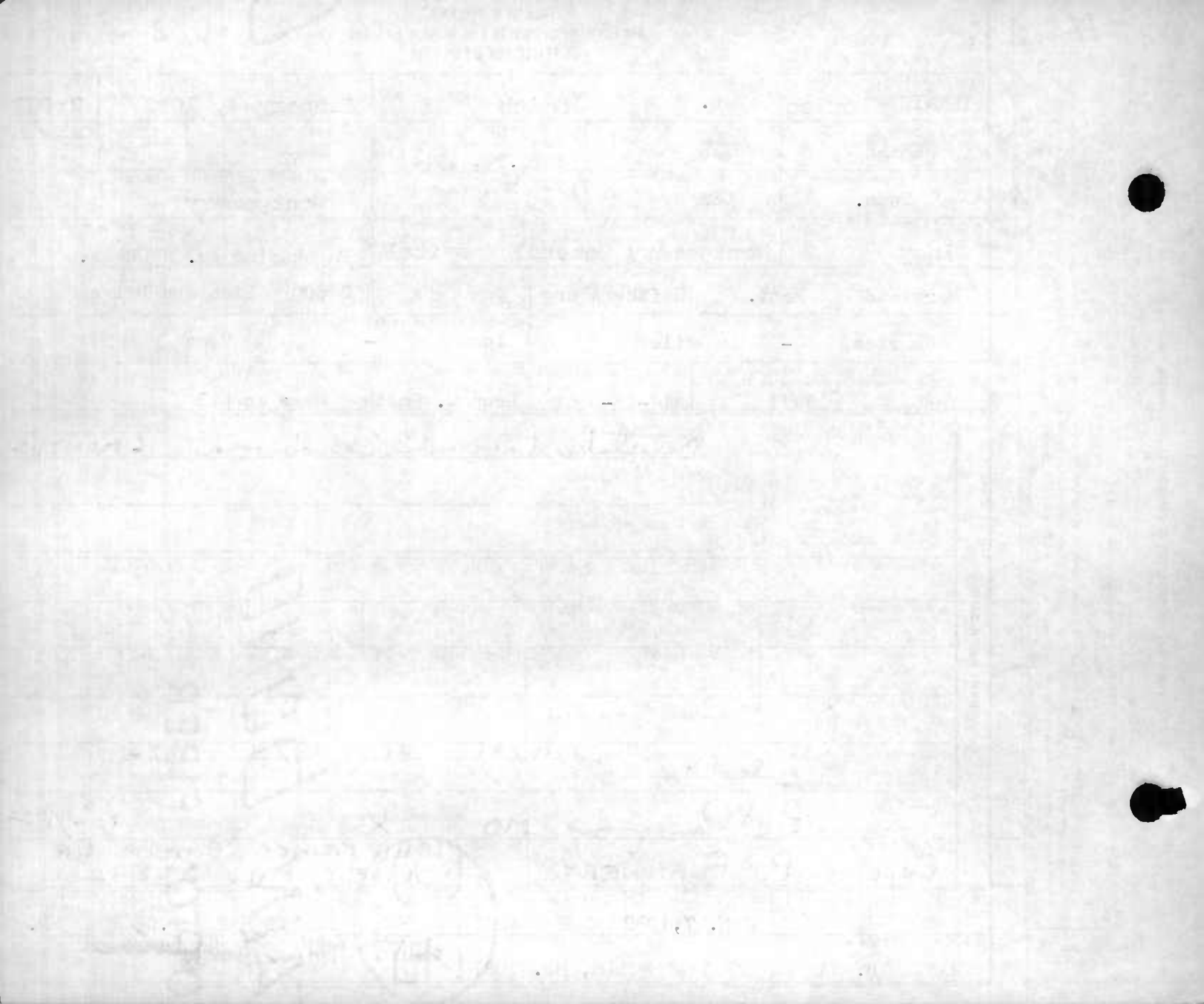
201 1183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 0 2 3 4 4			
1- FOR STATE REGISTRAR				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) TENNIE Louise B. Smith				2a DATE OF DEATH January 4, 1982		2b HOUR 2:50 P.M.	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 22, 1914		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Purchasing Ag.		12b KIND OF BUSINESS OR INDUSTRY USGov.	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b COUNTY Mont.		13c CITY OR TOWN Gaithersburg		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Charles - Biles				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez - Rose			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WWII 414-03-9661		17 INFORMANT ADDRESS Leon G. Smith Same as #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Pancreatic Carcinoma</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/10/81</u> 19 <u>81</u> to <u>1/4</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b SIGNATURE <u>Eugene P. J. Flannery</u>				DEGREE MD		22c. DATE SIGNED 1/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY				22e ADDRESS 18111 PRINCE PHILIP DR. OLNEY, MD. 20832.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY CHELTENHAM CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CHELTENHAM P. GEORGE MD.	
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER				ADDRESS LAYTONSVILLE, MD. 20879			





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2

0 2

3 4 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>TYVELLE DEON SMITH</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 12, 1982</b>			2b HOUR <b>12:30AM</b>				
3 SEX <b>MALE</b>		4 RACE <b>BLACK</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JAN. 11, 1982</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>(newborn)</b> -0- YRS		7a IF UNDER 1 YEAR MONTHS DAYS <b>2 5</b>		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD				
10 CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MONTGOMERY GENERAL HOSPITAL</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NEWBORN MALE INFANT</b>		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b>			13b COUNTY <b>Montg.</b>		13c CITY OR TOWN <b>Rockville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS (Tina's address) <b>709 Lenmore Avenue, #C-1</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>ROBERT EUGENE SMITH</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>TINA MARIE PRATHER</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NONE</b>		17 INFORMANT ADDRESS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>premature infant (25 wks gestation)</b> <b>7651</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a DATE OF OPERATION <b>NONE</b>			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thomas G. Tanton, MD</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas G. Tanton, M.D.</b>						22e. ADDRESS <b>18111 Prince Philip Drive Olney, Maryland 20832</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>HOSP. DISPOSAL</b>			23b. DATE <b>1/12/82</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME			ADDRESS			25 DATE RECD. BY REGISTRAR		25 REGISTRAR'S SIGNATURE		

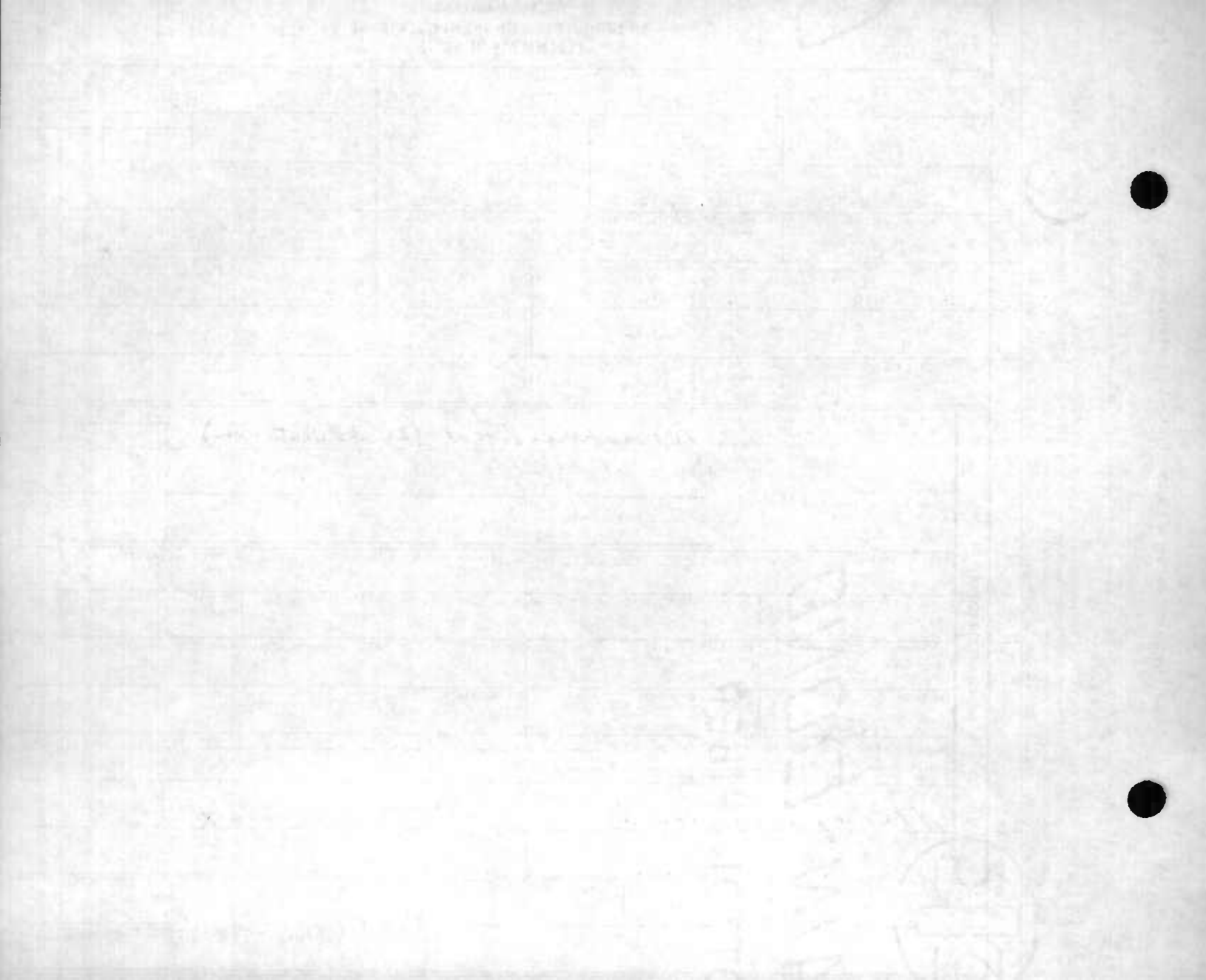
MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and, completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.





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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 4 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alexander NMN Sogolow</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 19 1982</b>		2b. HOUR <b>1725</b> M	
3. SEX <b>Male</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 09 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>U.S.S.R.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S. (Naturalized)</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Officer Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Military</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Chevy Chase</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4620 N. Park Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Boris Sogolow</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rose Sigal</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1952-1972</b>		17. INFORMANT ADDRESS <b>Chevy Chase, Md.</b> <b>Phyllis Sogolow 4620 N. Park Ave.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>2028</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>RESPIRATORY FAILURE</b> (c) <b>LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>13 October</b> 19 <b>81</b> to <b>19 January</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>19 January</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>BH Strand</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>19 JAN 82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BH STRAND</b>		22e. ADDRESS <b>NNMC Bethesda, MD 20014</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 21, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>
24. FUNERAL DIRECTOR NAME <b>Joseph Lawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash. D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		

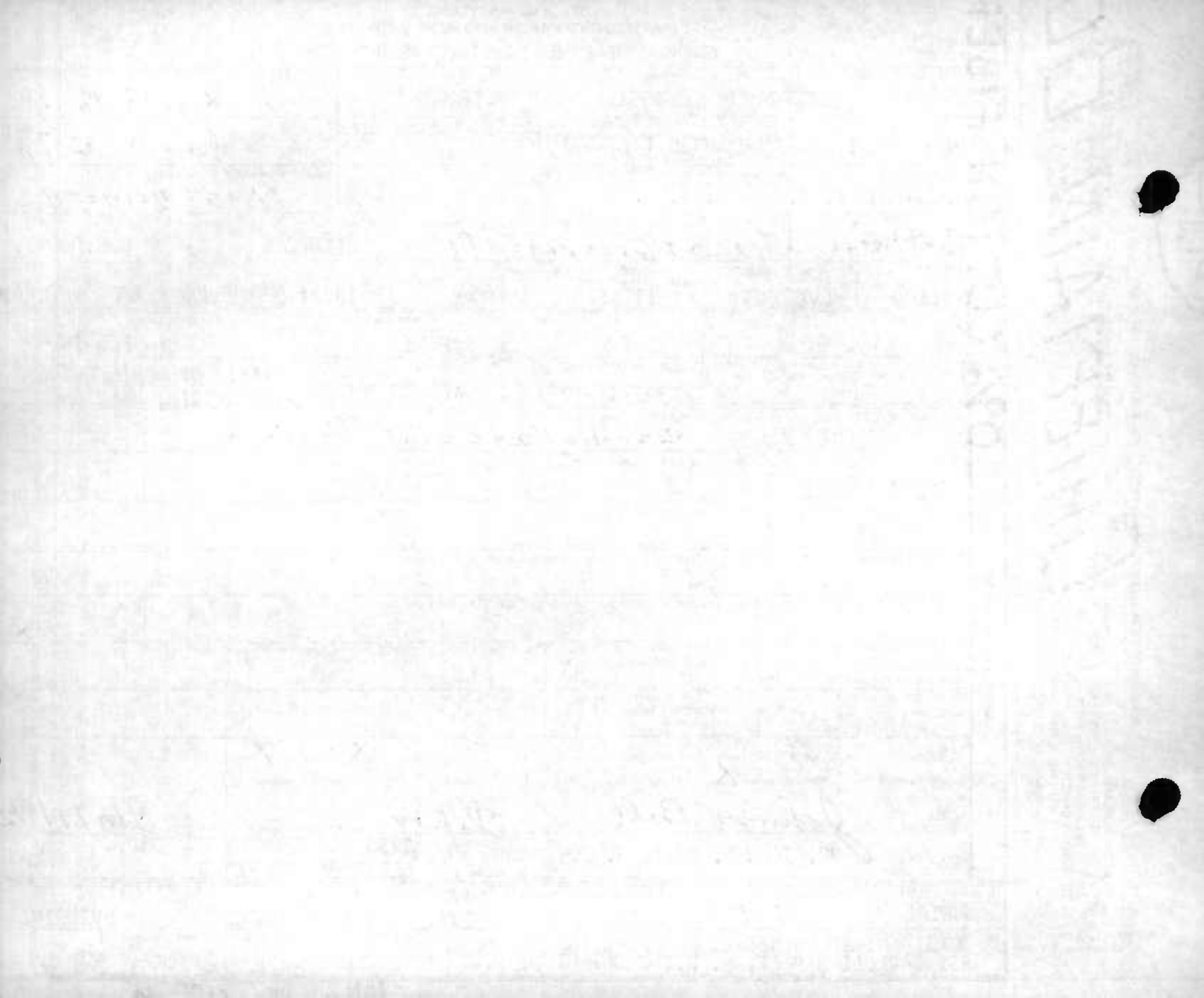


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73  
(VR A15 ME (5))

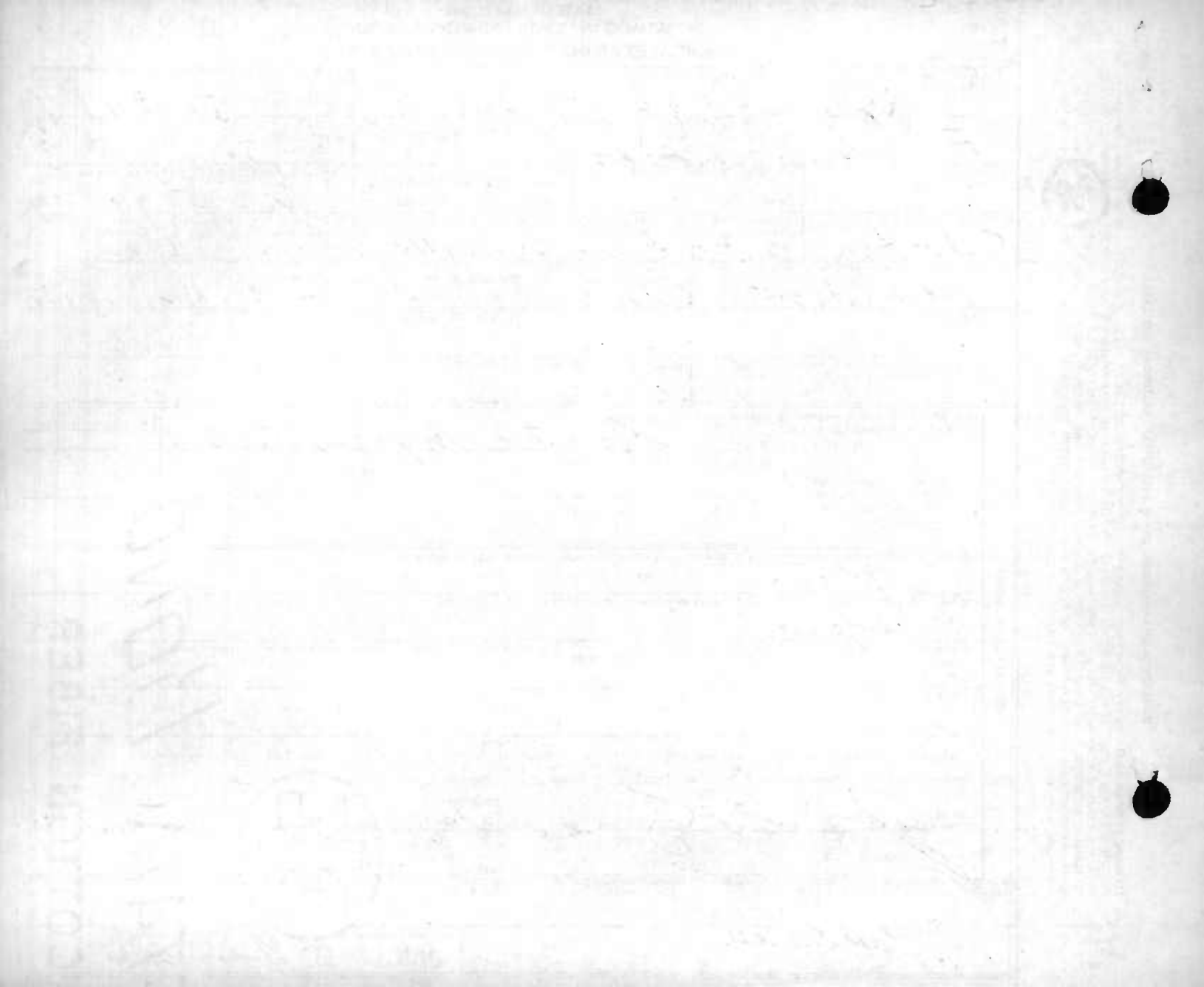
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02347	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA LOUISE SOLDANO</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>1-18-82</b>		2b. HOUR <b>PM</b>			
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>JANUARY</b> DAY <b>20</b> YEAR <b>1904</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>78</b> YRS.	IF UNDER 1 YR. MONTHS <b>XX</b> DAYS <b>XX</b>	IF UNDER 24 HRS. HOURS <b>XX</b> MIN <b>XX</b>	7c. DATE PRONOUNCED DEAD <b>Jan. 18 1982</b>		7d. HOUR <b>7:32 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10201 Grosvenor Pl.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERICAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>BETHESDA</b>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10201 GROSVENOR PLACE, APT. 907</b>			
14. FATHER'S NAME FIRST <b>JACOB</b> MIDDLE <b>SHEER</b> LAST <b>SHEER</b>				15. MOTHER'S MAIDEN NAME FIRST <b>SOPHIE</b> MIDDLE <b>ROBBIN</b> LAST <b>ROBBIN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-12-8772</b>		17. INFORMANT <b>MATTHEW SOLDANO, 12914 GRENOBLE DRIVE, ROCKVILLE, MARYLAND</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John G. Ball</b>			TITLE (SPECIFY) <b>M.D. Deputy</b>		MEDICAL EXAMINER <b>1936 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND</b>			DATE SIGNED <b>Jan 19 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>DR. JOHN G. BALL, M. D.</b>			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/20/1982</b>		23c. NAME OF CEMETERY OR CREMATOR <b>GARDEN KING DAVID MEMORIAL</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>FALLS CHURCH, VIRGINIA</b>				
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>					
232 CARROLL STREET, N. W., WASHINGTON, D.C.											

JAN 25 1982



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND										REG. NO.	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										0 2 3 4 8	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <b>Mabel Elizabeth Speaks</b>				3a. DATE KNOWN OF DEATH <b>Jan 9, 1982</b>				3b. HOUR <b>1:35</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Aug 18, 1929</b>		6. AGE IN YEARS (LAST BIRTHDAY) <b>52</b> YRS		7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		7c. DATE PRONOUNCED DEAD <b>Jan 9, 1982</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		7d. HOUR <b>1:35</b>	
10. CITY OR TOWN OF DEATH <b>Calverton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2504 McHenry Dr</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary, N. I. H.</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Calverton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2504 McHenry Dr.</b>			
14. FATHER'S NAME FIRST <b>Hanley</b> MIDDLE <b>Mitchell</b> LAST <b>Melton</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Ollie</b> MIDDLE <b>Melton</b> LAST <b>Melton</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>246-28-2134</b>				17. INFORMANT <b>John S. Speaks</b>				ADDRESS <b>2504 McHenry Dr. Sil. Spr., Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis</b> IMMEDIATE CAUSE (a) <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>4291</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4291</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep.</b> M.D. <b>Dep.</b> MEDICAL EXAMINER				DATE SIGNED <b>Jan 9, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>				ADDRESS <b>Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/13/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>				ADDRESS <b>P.O. Box 7428 Sil. Spr., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas J. Paster</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 4 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Lattimore Speare			2a. DATE OF DEATH MONTH DAY YEAR Jan. 13 1982		2b. HOUR 11:15pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June, 30, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill-Bethesda		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY None None			13c. CITY OR TOWN Wash. D.C.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3817 - 5th Street, N.W.
14. FATHER'S NAME FIRST MIDDLE LAST Willis Speare		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Lattimore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 221-24-6765	17. INFORMANT ADDRESS 821 - 15th St. NW Attorney - Robert E. Lynch Wash, D.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Atrial Fibrillation</u>					
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <u>None</u>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>None</u>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 22</u> 19 <u>81</u> to <u>present</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/11</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John B. Umhau</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>1/14/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John B. Umhau, MD</u>		22e. ADDRESS <u>8805 Conn. Ave., Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 19, 1982	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20815	
24. FUNERAL DIRECTOR <u>DeVol Funeral Home</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 25 1982</u>		25b. REGISTRAR'S SIGNATURE <u>Thane Jantzen</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

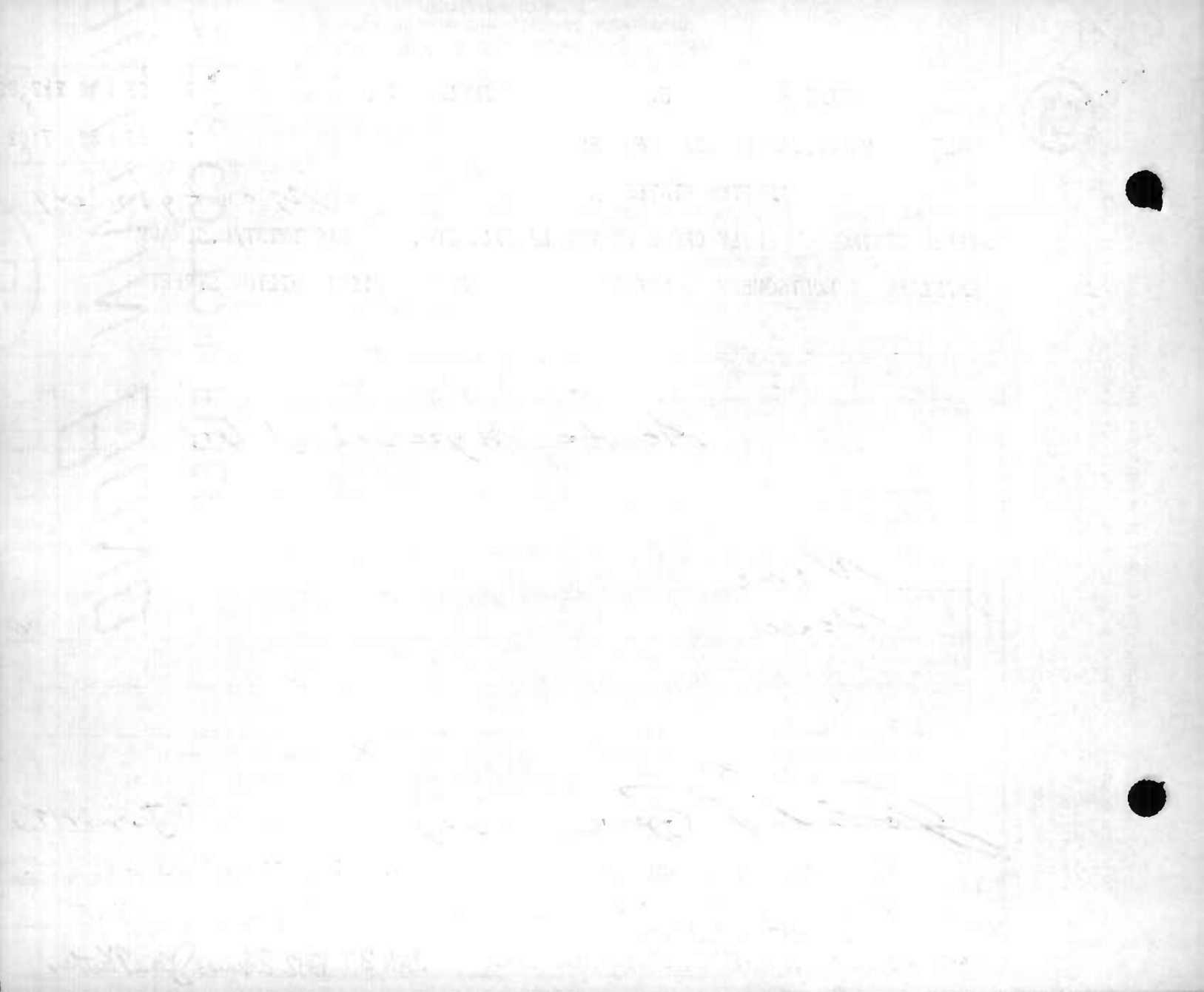
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 5 0	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM E. SPINDLER JR.										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 23 82	
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR MALE CAUCASIAN 5 26 55										2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 23 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) 7b. CITIZEN OF WHAT COUNTRY? WASHINGTON, D.C. UNITED STATES USA										9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION SILVER SPRING HOLY CROSS HOSPITAL/ SIL. SPG.										12a. USUAL OCCUPATION (TYPE OF WORK) 12b. KIND OF BUSINESS OR INDUSTRY MACHINIST/U.S. NAVY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND MONTGOMERY WHEATON										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 72013 MILTON STREET	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM E. SPINDLER										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES SHEEHAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES) WW II										16b. SOCIAL SECURITY NO. 577-40-8143	
17. INFORMANT ADDRESS JEAN C. SPINDLER SAME AS 13 WIFE											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <u>John S. Rogers</u> TITLE (SPECIFY) M.D. <u>Dep</u> MEDICAL EXAMINER										DATE SIGNED <u>Jan 27/82</u>	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 1/27/82	
23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY										23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 27 1982 Francis Jean Nathan	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 5 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Delilah E. Sproles</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 6 1982</b>		2b. HOUR <b>5:30 P</b>						
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7, 1894</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10 CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Circle Manor Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Damascus</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>10108 Lewis Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Williams</b>						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Melssie Nichols</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17 INFORMANT <b>Son</b>				ADDRESS <b>Same as item 13</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR INSUFFICIENCY</b> <b>4379</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 YEARS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SENILE INANITION</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>June 1, 1982</b> to <b>June 6, 1982</b> , that (1) (we) last saw the deceased alive on <b>June 6, 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.											
22b. SIGNATURE <b>MARYL C. SHARTEL M.D.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/6/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARYL C. SHARTEL M.D.</b>						22e. ADDRESS <b>3720 FARRAGUT AVE. KENSINGTON MD - 20895</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 11, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

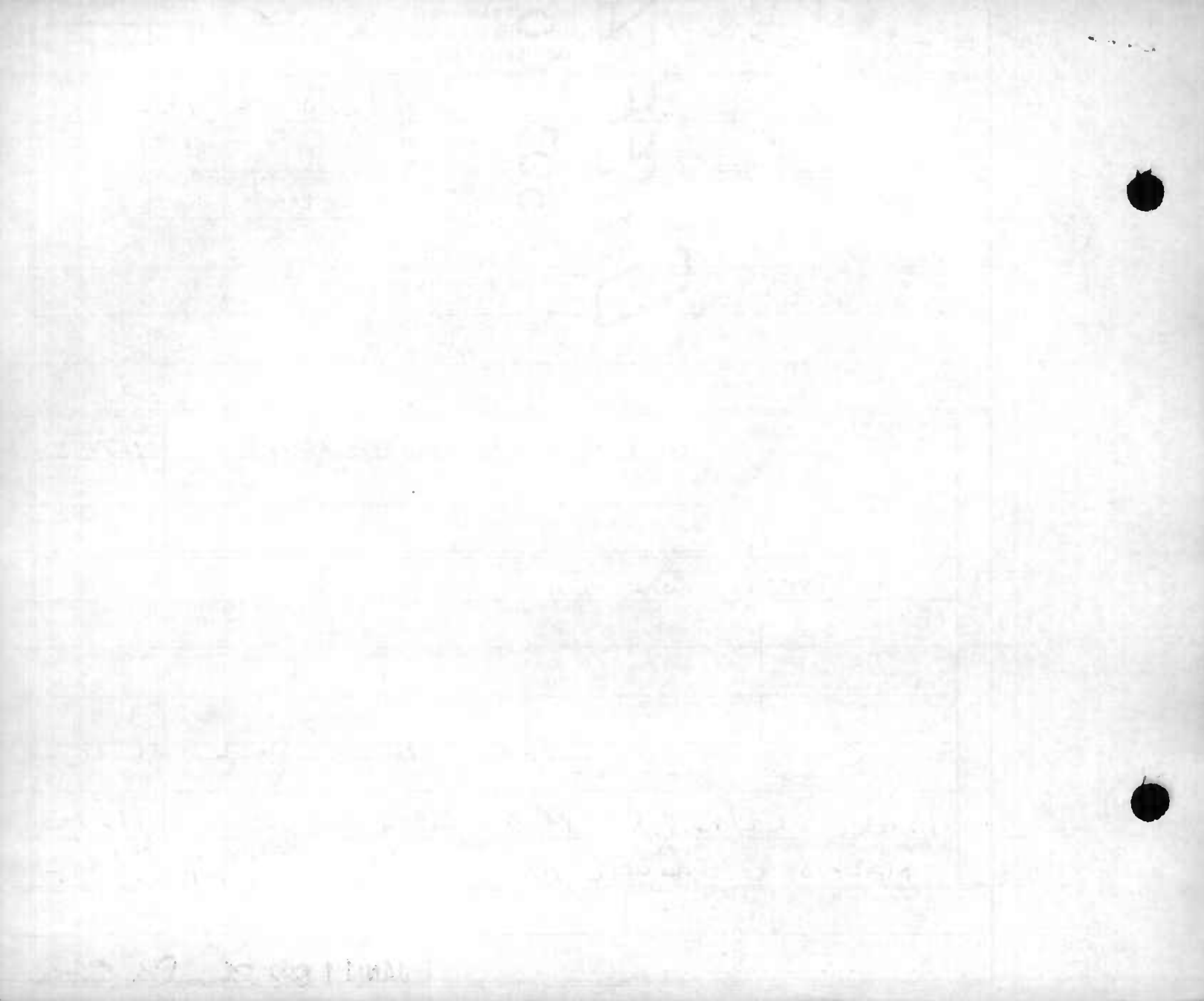
29

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 5 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PEARL N. STATEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-31-82</b>		2b. HOUR <b>1:45 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 15 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk Typist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Suburban Trust</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis A. Day, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>C. Estelle Terrell</b>		13e. STREET ADDRESS <b>1314 Dilston Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-26-4179</b>		17. INFORMANT ADDRESS <b>Maurice G. Staten Husband Same as 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Disease</b> <b>1579</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ISLET CELL CANCER OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b> <b>2 years</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>ZOLLINGER-ELLISON Syndrome (2 years)</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 15, 1980</b> , to <b>31 Jan 1982</b> , that (I) (we) lost saw the deceased alive on <b>31 Jan 1982</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Eugene P. Liboe M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>31 Jan 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. LIBOE M.D.</b>		22e. ADDRESS <b>10400 CONNECTICUT AVE KENSINGTON, MD 20891</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 3, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis J. Collins</b> NAME ADDRESS <b>500 University Blvd., W. Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	



MEMORANDUM FOR THE DIRECTOR

DATE: 10/15/54

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

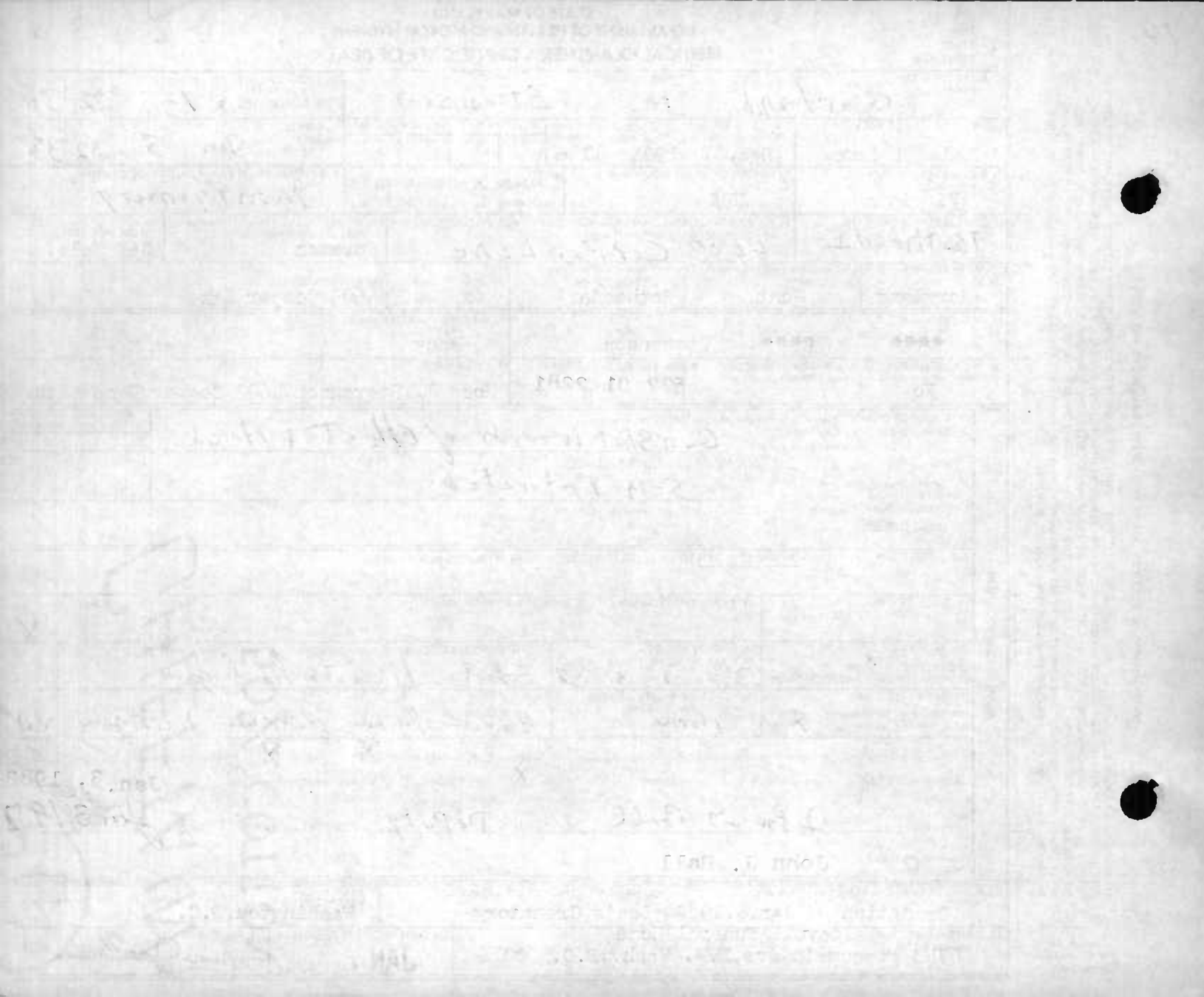
SUBJECT: [Illegible]

[The body of the memorandum contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a standard memorandum format with a subject line, followed by several lines of body text.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 5 3					
1. DECEASED NAME (TYPE OR PRINT) <b>Garland M. Stevenson</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 1-3 1982</b>		2b. HOUR <b>3P</b>		2c. DATE PRONOUNCED DEAD <b>Jan 3 1982</b>		2d. HOUR <b>3P</b>			
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 7 1901</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>80 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>Jan 3 1982</b>		7d. HOUR <b>3P</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4603 Cooper Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P Tele.</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4603 Cooper Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>**** * Stevenson</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Walk</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>577 01 2281</b>		17. INFORMANT ADDRESS <b>Rose J. Stevenson 4603 Cooper Lane Beth.Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wounds of Eldest + Head.</b> <b>9550</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Self Inflicted.</b> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3 P.M. 1-3 1982</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot self with hand gun.</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home.</b>				21f. LOCATION STREET <b>4603 Cooper Lane</b>		CITY OR TOWN <b>Bethesda</b>		COUNTY <b>Montgomery</b>		STATE <b>Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John J. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>Jan 3, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John J. Ball</b>				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>Jan. 4, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>				23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b>				COUNTY STATE	
24. FUNERAL DIRECTOR <b>Altavall Funeral Home</b>												25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
NAME <b>4748 Wisconsin Ave, N.W. Wash., D.C. 20016</b>												ADDRESS			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) <del>ANITA</del> ANITA		FIRST INEZ		MIDDLE STROUP		LAST		2a. DATE OF DEATH MONTH DAY YEAR 1/13/82		2b. HOUR 3 P M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6/12/1895		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOK GLOVE NRG HOME						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE VA		13b. COUNTY —		13c. CITY OR TOWN ALEXANDRIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4901 SEMINAR RD ALEXANDRIA VA			
14. FATHER'S NAME FIRST MIDDLE LAST JOHN — PRATHER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NELLIE — BAILEY									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 312-16-6880		17. INFORMANT VIRGINIA WIEGE		ADDRESS 14019 BARDOT ST., ROCKVILLE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Respiratory Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause: (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF bacterial pneumonia RML										2 hr	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus Hypertension CV Disease											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 12/12/81 to 1/13/82 that (1) (we) lost saw the deceased alive on 1/13/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.											
22b. SIGNATURE C.H. Kugan MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/13/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 1811 P. Parkway Dr., Olney MD 20832									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/19/82		23c. NAME OF CEMETERY OR CREMATORY MEMORIAL GARDEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE TRAVERSE CITY MICHIGAN					
24. FUNERAL DIRECTOR NAME UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JAN 21 1982		25b. REGISTRAR'S SIGNATURE Francis J. Collins							

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1. The piston is at the bottom of the cylinder.  
2. The piston is at the top of the cylinder.  
3. The piston is at the bottom of the cylinder.  
4. The piston is at the top of the cylinder.



5. The piston is at the bottom of the cylinder.  
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13. The piston is at the bottom of the cylinder.  
14. The piston is at the top of the cylinder.  
15. The piston is at the bottom of the cylinder.  
16. The piston is at the top of the cylinder.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 5 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Thomas Sullivan			2a. DATE OF DEATH MONTH DAY YEAR January 4, 1982		2b. HOUR 11:15 AM
3 SEX MALE	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 9 2 00	6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER	12b. KIND OF BUSINESS OR INDUSTRY Agriculture	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. CITY OR TOWN Howard	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 13840 Triadelphia Rd
14. FATHER'S NAME FIRST MIDDLE LAST Sullivan John		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Saddie Selby			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 022-26-4767	17. INFORMANT ADDRESS Bessie Sullivan Glenelg, Md.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 2384 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Polycystic degeneration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 days</u> <u>5 years</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Below knee amputation left leg 1 week prior to CVA</u>					
19a. DATE OF OPERATION 19 Dec 81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene left foot		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12 December, 1981</u> to <u>3 Jan, 1982</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N. Thomas Debevoise</u>		DEGREE MD		22c. DATE SIGNED 1/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. Thomas Debevoise MD		22e. ADDRESS 18111 Prince Phillip Dr. Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-6-82	23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Glenelg Howard MD.	
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Lykenville, Md.		25a. DATE REC'D. BY REGISTRAR JAN 6 1982	
		25b. REGISTRAR'S SIGNATURE <u>James G.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





1. The first part of the report is a general  
 introduction to the subject of the study.  
 2. The second part is a description of the  
 methods used in the study.  
 3. The third part is a description of the  
 results of the study.  
 4. The fourth part is a discussion of the  
 results of the study.  
 5. The fifth part is a conclusion of the  
 study.  
 6. The sixth part is a list of references.  
 7. The seventh part is an appendix.  
 8. The eighth part is a list of figures.  
 9. The ninth part is a list of tables.  
 10. The tenth part is a list of abbreviations.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHM - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Walter F. Sutter</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 19, 1982</b>					2b. HOUR <b>12:10P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 24 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing And Conv. Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-Employed Investments</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4201 Cathedral Ave., N.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Sutter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>012-16-5159</b>		17. INFORMANT ADDRESS <b>Edna Gordon 5219 Cedar Lane Bethesda, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> 5 YRS DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b> 10 YRS.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>URINARY TRACT INFECTION</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 78</b> to <b>JAN 19 82</b> , that (I) (we) lost saw the deceased alive on <b>JAN 13 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Frank G. MacMurray, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-19-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank G. MacMurray, M.D.</b>				22e. ADDRESS <b>3301 N. M. Ave. N.W. Wash/DC</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/26/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Culpeper National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Culpeper Virginia</b>					
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>				24. ADDRESS <b>5130 Wise. Ave., N.W. Wash., D. C.</b>		25. DATE RECEIVED BY REGISTRAR <b>JAN 25 1982</b>		25. SIGNATURE <b>Frank G. MacMurray</b>			

MEDICAL CERTIFICATION

THE UNIVERSITY OF CHICAGO

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										REG. NO.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FATMA TAHA</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-5-82 19		2b. HOUR M			
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 12, 1940</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>41</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1-7-82 19</b>		2d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Egypt</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Egypt</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5500 Kirkside Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nurse/Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5500 Kirkside Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unavailable</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unavailable</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Unavailable</b>		17. INFORMANT ADDRESS <b>Wash., D.C. 20008</b> <b>Cora Seballos, 2300 Decatur Pl., N.W.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Undetermined</b> <b>7999</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margareta A. Korell</i>		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 1-8-82			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>		ADDRESS <b>111 Penn Street</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 23, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alexandria Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Egypt</b>					
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home, Inc.</b>				ADDRESS <b>Wash., D.C. 2222 Wisc., Ave., N.W.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>			

1901-1910

1911-1920

1921-1930

1931-1940

1941-1950

x

1951-1960

1961-1970

1971-1980

1981-1990

1991-2000

2001-2010

2011-2020

2021-2030

2031-2040

2041-2050

2051-2060

2061-2070  
2071-2080  
2081-2090  
2091-2100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 3 5 8	
1. DECEASED NAME (TYPE OR PRINT) <b>James A. Taylor, Sr.</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>1-23, 1982</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>10</b> YEAR <b>'08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		2c. DATE PRONOUNCED DEAD <b>Jan 23, 82</b>		2d. HOUR <b>12 P.M.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Landscaping</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Private</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Germantown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>15501 Germantown Rd.</b>			
14. FATHER'S NAME FIRST <b>Thomas</b> MIDDLE <b>Robert</b> LAST <b>Taylor, Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Nettie</b> MIDDLE <b>Virginia</b> LAST <b>Arnold</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-07-2599</b>		17. INFORMANT <b>Violet C. Taylor</b>		ADDRESS <b>15501 Germantown Rd. Germantown, Md. 20874</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute.</b> 4110 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd., Bethesda, Md</b>				DATE SIGNED <b>Jan 23, 1982</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/25/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>				23d. LOCATION CITY OR TOWN <b>Washington, D.C.</b> COUNTY STATE			
24. FUNERAL DIRECTOR <b>Gartner Sandison 316 E. Diamond Avenue, Gaithersburg, Md. 20877</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1982</b>		25b. REGISTRAR'S SIGNATURE			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES H. TAYLOR, SR.</b>				2a. DATE OF DEATH MONTH DAY YEAR 1-9-82			
3. SEX <b>Male</b>				2b. HOUR 3:50 <sup>a.m.</sup>			
4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR 1 8- 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Germantown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17601 Burdette Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Germantown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Taylor</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Nicholson</b>		13e. STREET ADDRESS <b>17601 Burdette Lane</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-30-0585</b>		17. INFORMANT <b>Mrs Ruby Dyson (Daughter) Same As 13#E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROSIS</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> 19 <b>82</b> to <b>1/9</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alfred Muller</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALFRED MULLER</b>		22e. ADDRESS <b>3301 New Mexico Ave., N.W/ Washington, D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-12-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Germantown, Montg. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b> ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b>				25a. DATE RECD. BY REGISTRAR <b>JAN 11 1982</b> REGISTRAR'S SIGNATURE <b>James J. Nathan</b>			





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*[The main body of the document contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several paragraphs and possibly a list or table structure.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP \_\_\_\_\_  
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 5 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ELAORA Terry</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 - 16 - 82</b>		2b. HOUR <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>RIK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 18 - 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mississippi</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silverspring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
13a. STATE <b>Mississippi</b>		13b. CITY OR TOWN <b>Attala Kosciusko</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>route 2 Box 429</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Noah Cooke</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Essie Brister</b>		16. SOCIAL SECURITY NO. <b>425 88 8598</b>			
17. INFORMANT <b>Frida Satter Field</b>		ADDRESS <b>Brister</b>					
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>no</b>		19. SOCIAL SECURITY NO. <b>425 88 8598</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perirectal Abscess</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>5660</b> (b) <b>3 wks</b> (c) <b>3 wks</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <b>12/21</b> , 19 <b>81</b> , to <b>1/16</b> , 19 <b>82</b> , that (1) (we) lost saw the deceased alive on <b>1/15</b> , 19 <b>82</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did not view the body after death.							
22b. SIGNATURE <b>Peter Sherer MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/16/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PETER. B SHERER</b>		22e. ADDRESS <b>1109 Spring St. #610 Silver Spring md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial: removal</b>		23b. DATE <b>1-21-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kosciusko Attala Miss.</b>	
24. FUNERAL DIRECTOR NAME <b>FRAZIER'S</b>		ADDRESS <b>389 R.I. Ave. NW Wash. DC 20001</b>		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 21 1982 James J. Nathan</b>			



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DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The information obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner ~~must~~ be notified at once.

Item 16a g564 2/11/82 gj		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 3 6 1	
1 - STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		7a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
Norman R Tharp				01/18/82 1327 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		Caucasian		09/07/12	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
Ohio		USA		69 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Rockville		Shady Grove Adventist Hospital		Montgomery MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INDUSTRY		12b. STATE DEPARTMENT OF BUSINESS OR			
Agency International Devel.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Virginia		Fairfax		McLean	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	
Ray G. Tharp		Margaret Alta Conn		No Yes WW II	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
275 01 7727		Jane W. Tharp Wife-same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE YEARS YEARS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES NO YES NO	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 1/11/82 and that (my) (our) opinion death occurred on the date and hour and from the causes stated		22b. SIGNATURE DEGREE 22c. DATE SIGNED			
Thos G. Ward MD		ATTENDING PHYSICIAN MEDICAL DIRECTOR PHYSICIAN		1/18/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Thos G. Ward		6116 Robinwood, Bethesda, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		Jan 18, 1982		Metropolitan Crematory, Alexandria, Va	
24. FUNERAL DIRECTOR'S NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE	
Pearson's Funeral Home		Falls Church, Va. 22046		JAN 20 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO. 8202362			
FOR 1- STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Phrixos Theodorides</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-82</b>		2b. HOUR <b>6:39 AM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-09-92</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>84</b> 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Tatoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sligo Gardens</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LAST YEAR) <b>Professor Physics</b>		12b. KIND OF BUSINESS OR <b>Teacher</b>	
13a. STATE <b>9906</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>S.S. Md 20901</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9906 Woodburn Rd S.S. Md 20901</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Manuel Theodorides</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Calypso - Emmanuel</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No --</b>				16b. SOCIAL SECURITY NO. <b>013-261593A</b>		17. INFORMANT ADDRESS <b>Marcelle M. Theodorides, same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Pneumonia</b> <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12/10/80</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>1/17/82</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>831 University Blvd E. Silver Spring, Md 20903</b>		22c. DATE SIGNED <b>1/17/82</b>	
22a. I certify that (I, this hospital) attended the deceased from <b>12/10/80</b> to <b>1/17/82</b> , that (I) <input checked="" type="radio"/> saw the deceased alive on <b>1/17/82</b> , and that in (my) <input checked="" type="radio"/> own opinion death occurred on the date and hour and from the causes stated above (I) <input type="radio"/> (we) <input type="radio"/> (did) <input type="radio"/> and not view the body after death.				22b. SIGNATURE DEGREE <b>David Cromwell MD</b>		22c. DATE SIGNED <b>1/17/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Cromwell</b>				22e. ADDRESS <b>831 University Blvd E. Silver Spring, Md 20903</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 23, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>First Athens Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Athens, Greece</b>	
24. FUNERAL DIRECTOR (NAME) <b>DeVol Funeral Home, Inc., 2222 Wisc. Ave., N.W.</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 25 1982</b>			

John Marshall Theodorides -  
 Marcelle M. Theodorides, same as above

x x

Funeral Home, Inc., 1222 W. 4th St., Wash. D.C.  
 Jan. 23, 1982  
 First  
 Athens Cemetery, Athens, Greece



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR										2. DATE OF DEATH									
3-1-82 AL Item 22a. DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 0 2 3 6 3									
CERTIFICATE OF DEATH										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH									
FIRST MIDDLE LAST										MONTH DAY YEAR									
Lulu Y. THOMAS										JANUARY 23 1982									
3. SEX										4. RACE									
FEMALE										Caucasian									
5. DATE OF BIRTH										6. AGE (IN YEARS LAST BIRTHDAY)									
MONTH DAY YEAR										YEARS MONTHS DAYS HOURS MIN.									
11 19 86										95									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?									
New York										U.S.A.									
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH									
10. CITY OR TOWN OF DEATH										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)									
Bethesda										housewife									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12b. KIND OF BUSINESS OR INDUSTRY									
Bethesda Retirement Home										Home									
13a. STATE										13b. CITY OR TOWN									
Md.										Bethesda									
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST										FIRST MIDDLE LAST									
Valentine Young										Wilhelmina Herr									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.									
NO										-216-56-2980									
17. INFORMANT										ADDRESS									
Son										William A. Pates									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) 5355 Isastitis Hemorrhage										12 hrs									
DUE TO, OR AS A CONSEQUENCE OF (b) Aspin Isastitis pain										24 hrs.									
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10																			
Senile Dementia																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY?										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>										YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY									
										HOUR A.M. MONTH DAY YEAR									
										P.M. 19									
21d. INJURY OCCURRED										21e. PLACE OF INJURY									
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>										[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]									
21f. LOCATION										21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)									
STREET										CITY OR TOWN COUNTY STATE									
22a. I certify that (we) (this hospital) attended the deceased from December 19 67 to January 24 19 82, that (I) (we) last saw the deceased alive on December 6 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										22c. DATE SIGNED									
Charles W. Humphreys, Jr. MD										1/23/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
Charles W. Humphreys, Jr. MD										1712 Eye St. N.W. Washington, D.C.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE									
Burial										1/26/1982									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION									
Cedar Hill Cemetery										Suitland Maryland									
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR									
NAME										25b. REGISTRAR'S SIGNATURE									
Joseph Gawler's Sons Inc.										JAN 27 1982									
5130 Wisc. Ave., N.W. Wash., D.C.										Francis J. Nutter									

John V. Thomas

11 12 75

Home

William

12 12 75

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

DHMH - 16 50M 1/81  
(VRA 15, 4)

Cleared by Dr. John S. Rogers, Deputy Medical Examiner

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 6 4	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) DELIA D. THOMPSON						2a. DATE OF DEATH MONTH DAY YEAR 1/22/82		2b. HOUR 0900 A.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.					
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville			
14. FATHER'S NAME FIRST MIDDLE LAST John F. Duncan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miranda Palmer		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1123 Maple Avenue					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- 219-70-2180		17. INFORMANT ADDRESS Ruby Chaconas Same as items 13 a-e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4140 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs 4 days 30 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1-8-82, 19, to 1-22, 1982, that (we) lost saw the deceased alive on 1-21-82, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated (above) (we) (did not) view the body after death.											
22b. SIGNATURE W. G. Hall		22c. DATE SIGNED 1/22/82		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) W.G. Hall		22f. ADDRESS 615 W. Montgomery Ave. Rockville, Md. 20850									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/25/82		23c. NAME OF CEMETERY OR CREMATORY White Rock Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE White Rock, Virginia					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc.		24b. ADDRESS 1331 Rockville Pike Rockville, Maryland 20852		24c. DATE REC'D. BY REGISTRAR JAN 28 1982							

REGISTRAR'S SIGNATURE



RECEIVED  
JAN 10 1952  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: Mr. W. H. Hall  
FROM: Mr. J. H. [illegible]  
SUBJECT: [illegible]  
DATE: [illegible]  
[Several lines of illegible text follow]

[Large block of illegible text, possibly a letter body or report content]

W. H. Hall  
[illegible]  
[illegible]  
[illegible]  
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MABEL MARY (GARNER) THOMPSON					2a. DATE OF DEATH MONTH DAY YEAR 1 27 82					2b. HOUR 2:03 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 16, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK			12b. KIND OF BUSINESS OR INDUSTRY SAFEWAY STORE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD COUNTY PG					13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 327 THOMAS DR. #6		
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT E. GARNER SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE KATHRYN NOBLE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO					16b. SOCIAL SECURITY NO. 579-03-6028		17. INFORMANT ADDRESS 2118 SARANAC ST. BROTHER - ROBERT GARNER JR. ADLPHI, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 4254 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ventricular fibrillation, asystole</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cardiomyopathy</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Congestive heart failure</u>											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>July 1-27</u> , 19 <u>82</u> , to <u>1-27</u> , 19 <u>82</u> , that (2) we last saw the deceased alive on <u>1-27</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we laid out the body after death, so state.)											
22b. SIGNATURE <u>J. Kijah</u>					DEGREE NO					22c. DATE SIGNED 1-28-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 1/30/82		23c. NAME OF CEMETERY OR CREMATORY St. Mary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co. Md.		
24. FUNERAL DIRECTOR FLECK LAUREL FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel, Md. 20707					25a. DATE REC'D. BY REGISTRAR FEB 1 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. Smith</u>				

BP

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Several lines of handwritten text, likely a list or notes, mostly illegible.

Handwritten text, possibly a paragraph or a list, mostly illegible.

Handwritten text, possibly a signature or a list, mostly illegible.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>MATTHEW C THOMPSON</b>					2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>January 14, 1982 9:15 AM</b>					
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b>		7b. UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>				
10. CITY OR TOWN OF DEATH <b>SELEERS Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Patent Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence A. Thompson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Edna Koch</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>480 22 9654</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Joyce Thompson Same as item 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4920</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Emphysema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/81</b> 19 <b>81</b> to <b>1/14</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/13/82</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.										
22b. SIGNATURE <b>Jay Weiner</b>					DEGREE		22c. DATE SIGNED <b>January 16, 1982</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jay Weiner</b>					22e. ADDRESS <b>4701 Randolph Rd Rockville, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 19, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairmont Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Davenport Iowa</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 22 1982</b>					
					25b. REGISTRAR'S SIGNATURE <b>Frances Van Thier</b>					

MEDICAL CERTIFICATION

29

0804



OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315



MEMORANDUM FOR THE SECRETARY OF THE ARMY  
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

Body released by Dr. Bail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice Trilling</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>6</b> YEAR <b>82</b>		2b. HOUR <b>11<sup>5</sup></b> P.M.	
3. SEX <b>female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>25</b> YEAR <b>10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		7. IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (IF OTHER THAN WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5480 Wisconsin Ave.</b>							
14. FATHER'S NAME FIRST <b>Leo</b> MIDDLE <b>Sulzberger</b> LAST <b>Joseph</b>				15. MOTHER'S MAIDEN NAME <b>Beatrice S. Joseph</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT NAME <b>Leonard J. Trilling</b> ADDRESS <b>Same as item # 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Acute pulmonary edema</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arterial Heart Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Diabetes Mellitus + Generalized Arteriosclerosis</b>											
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <b></b> A.M. <b></b> MONTH <b></b> DAY <b></b> YEAR <b></b> P.M. <b></b> <b>NA</b> <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> 19 <b>82</b> to <b>1/6</b> 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/5</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Adolph Friedman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/6/82</b>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Adolph Friedman</b>			
22e. ADDRESS <b>5454 Wisconsin Ave. Chevy Chase</b>											
23a. BURIAL, CREMATION, REMOVAL (IF OTHER, GIVE DETAILS) <b>Cremation</b>		23b. DATE <b>1-9-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>Prince George</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons</b> ADDRESS <b>Washington, D. C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1982</b>					
25b. REGISTRAR'S SIGNATURE <b>Phyllis Van Hatten</b>											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 4 AND 5 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 6 8	
1. FOR - STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY TUCCI										2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 7 1982	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 9 25 11		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 7 1982	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY Plumbing	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4949 Battery Lane #215	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Tucci						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carmela DiPonziano					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Mrs. Helen A. Tucci, Wife Same as item #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John G. Ball</u>				TITLE (SPECIFY) M.D. <u>Deputy</u>				MEDICAL EXAMINER		DATE SIGNED <u>Jan 7, 1982</u>	
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball, M.D.				7936 Old Georgetown Rd., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park, Rockville, Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 14 1982		25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>			

20% COTTON FIBER

100% COTTON FIBER



Green & White  
Cotton & Linen

John Ball  
Cotton & Linen

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. **Important:** If item 21 is marked or item 18 shows injury, or other traumatic event, the medical examiner must be notified at once.

Released by *Dr. John Bell Deputy M.D.*

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 6 9				
1. FOR STATE REGISTRAR				2c. DATE OF DEATH MONTH DAY YEAR				2b. HOUR
1. DECEASED NAME FIRST MIDDLE LAST <i>Turner Isabel M. Turner</i>				12 82				12 <sup>33</sup> PM
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 12 15 87		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD				
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) US Gov't. Bureau of Eng.		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MONT. COUNTY		13a. CITY OR TOWN S.S.	13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS 2105 Arcola Ave.				
14 FATHER'S NAME FIRST MIDDLE LAST William Knott		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Carlin						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 578 07 5240		17. INFORMANT ADDRESS Marie Musgrove (Daughter) Same as 13E				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>metastatic brain tumor</i> 1991 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos.	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 1</i> , 19 <i>81</i> , to <i>Jan 12</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>Jan 11</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Stuart L. Horwitz</i> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart L. Horwitz				22e. ADDRESS 4400 Connecticut Ave., NW Wash. DC 20008				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/15/82		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery Brentwood PG Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR Hines/Rinaldi F.H. 11800				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 14 1982 <i>Charles Jean Thurston</i>				

NOV 20 1964

James B. ...

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NOTED 10 JAN 14 1965



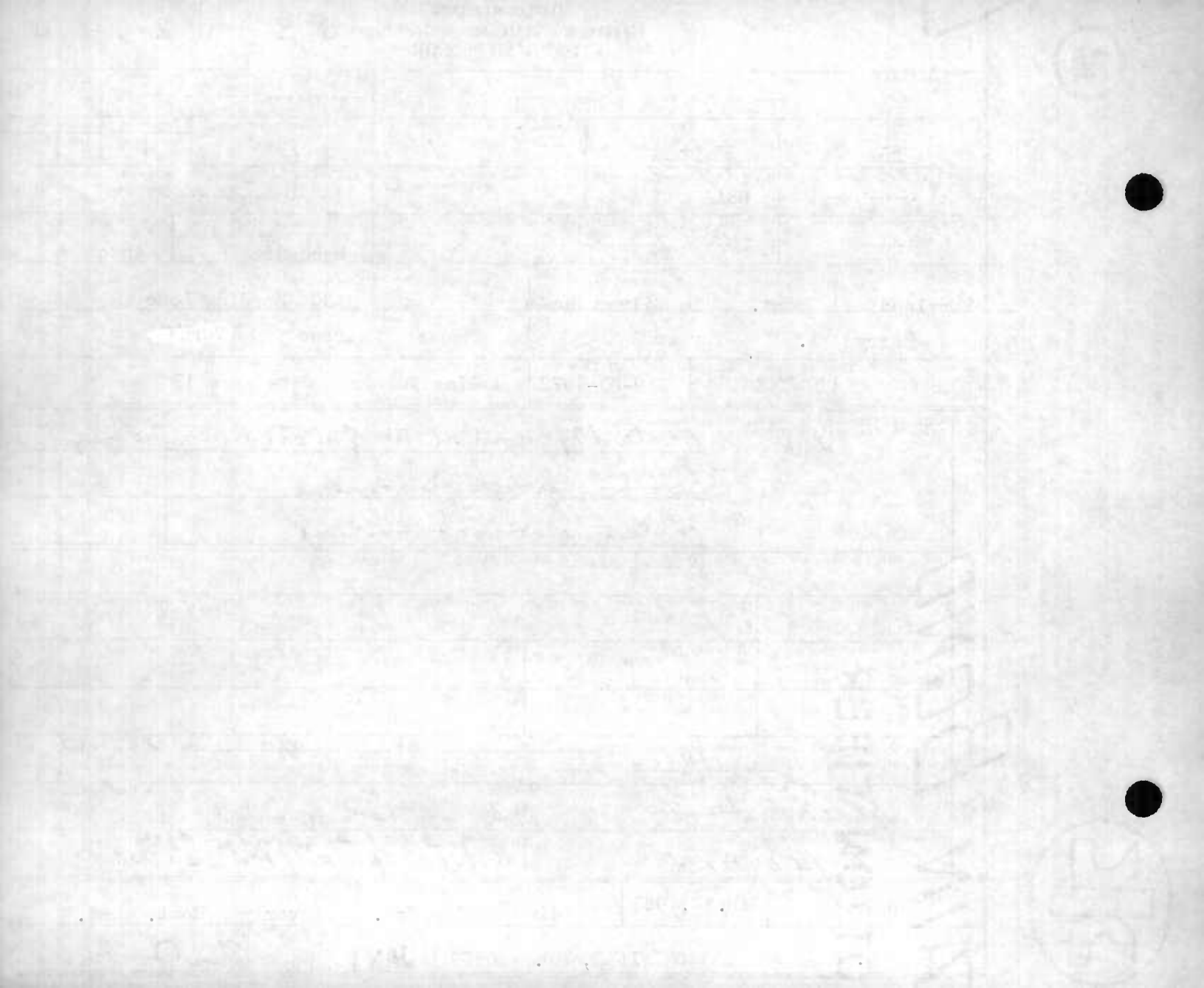
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 7 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
STIRLING C. TURNER				JANUARY 11, 1982		5:27PM	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR	
Male	White	JAN 01 05 14		68 YRS		MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	USA				MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
OLNEY	MONTGOMERY GENERAL HOSPITAL			Mechanic		Auto	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Mont.		Silver Spring		13e STREET ADDRESS	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Harry A. Turner		Maude Irene HARDING					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS			
NO		219-03-4972		Arline Turner Same as # 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>							6 days
4100 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Disease</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Myocardial Heart Failure</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>1/6</u> , 19 <u>82</u> , to <u>1/11</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/11/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>A. Rotstein</u>		MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
A. ROTSTEIN		3701 Rossman Blvd Silver Spring MD 20906					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		JAN. 14, 1982		Harding Family Cem.		Cloverly Mont. Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
FRANCIS H. BARBER		LAYTONSVILLE, MD. 20879		JAN 13 1982		<u>Francis H. Barber</u>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 7 1

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Freeman C. Twiss			2a. DATE OF DEATH MONTH DAY YEAR Jan. 26, 1982		2b. HOUR 12:30 P M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 20, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wyoming	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elect. Engineer	12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN Md. Montgomery Bethesda			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS 6036 Rossmore Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Malcolm N. Twiss		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Abigail Martin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 461-20-2601		17. INFORMANT ADDRESS Elta E. Twiss Same as item # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>		SUDDEN (minutes)
DUE TO, OR AS A CONSEQUENCE OF (c) <u>VENTRICULAR ECTOPY + CONGESTIVE HEART FAILURE</u>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  
DIABETES MELLITUS, GOVT. UREMIA, RHEUMATOID HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 19 56</u> to <u>JAN 26 82</u> , that (I) (we) lost saw the deceased alive on <u>JAN 20 82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Richard J. Meyer</u>	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-26-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard J. Meyer, M.D.		22e. ADDRESS 4731 Mass. Ave., N.W., Wash., D.C. 20016	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial	23b. DATE 1/29/82	23c. NAME OF CEMETERY OR CREMATORY Restlawn Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE El Paso, Tx.
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.		25a. DATE REC'D. BY REGISTRAR FEB 1 1982	25b. REGISTRAR'S SIGNATURE <u>James J. Martin</u>

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• 101 • Chapter 11

C. H. Joyner • G. Zeng • 25

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Abstract: This paper discusses the importance of the

1001-1002

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050

2001-02-28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 7 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Infant XXXXXXXX Ugorji				2a. DATE OF DEATH MONTH DAY YEAR JAN. 4, 1982		2b. HOUR 9:55 P.M.	
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR JAN 4, 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 1	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. CITY OR TOWN Montgomery Silver Spring		13c. STREET ADDRESS 1703 EAST WEST HIGHWAY	
14. FATHER'S NAME FIRST MIDDLE LAST Ebenzer C. Ugorji				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mihette Sterling			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Evenezer Ugorji Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 7651 Prematurity DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)							ADJUSTMENT INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/4/82 19 to 1/4/82 19, that (I) ( ) lost saw the deceased alive on above, (I) ( ) (did) (did not) view the body after death.							
22b. SIGNATURE Stanley H. Steinberg, M.D.				DEGREE M.D.		22c. DATE SIGNED 1/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STANLEY H. STEINBERG, M.D.				22e. ADDRESS 831 UNIVERSITY BLD., E. SILVER SPRING, MARYLAND 20903			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Jan. 11, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Va.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.				24b. ADDRESS Box 7428		25a. DATE OF DEATH JAN 4 1982	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 0 2 3 7 3									
1. DECEASED NAME (TYPE OR PRINT) <b>Wheaton Maryland Ung</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>1 19 82</b>										2b. HOUR <b>4:02 P.M.</b>																			
3. SEX <b>Male</b>		4. RACE <b>4 Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 81</b>		6. AGE (IN YEARS (LAST BIRTHDAY) YRS <b>3</b>		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 19 82</b>										2d. HOUR <b>4:02 P.M.</b>																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>										7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Montgomery County, MD.</b>									
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/A</b>										12b. KIND OF BUSINESS OR INDUSTRY									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12c. STATE <b>Maryland</b> 12d. COUNTY <b>Montgomery</b>										13c. CITY OR TOWN <b>Wheaton</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>2805 Radius Road</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mau Ung</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sim Im Hok</b>																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>										16b. SOCIAL SECURITY NO. <b>None</b>										17. INFORMANT ADDRESS <b>Mau Ung Same as item 13 a-e</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7980 Sudden Infant Death Syndrome</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>										TITLE (SPECIFY) <b>Assistant</b> M.D. MEDICAL EXAMINER										DATE SIGNED <b>1-20-82</b>																			
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>										ADDRESS <b>111 Penn Street</b>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>										23b. DATE <b>1-23-82</b>										23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>										23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>									
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b>										ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1982</b>										25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>									



Silver Spring Mont. Md.

1-23-82 Date of Death  
Tison Wheeler Funeral Home, Inc.  
1331 Rockville Pike Rockville, Md. 20852

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Vincent Marcel Usera		2a. DATE OF DEATH January 21 1982		2b. HOUR 12:58 M	
3. SEX Male	4. RACE Cauc	5. DATE OF BIRTH December 10 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4920 Sentinel Dr. Bethesda, Md.
14. FATHER'S NAME Jose Vicente Usera		15. MOTHER'S MAIDEN NAME Adrienne Luisa Battistini			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF NOT, GIVE WORK ID NO.) 1940-1963	17. INFORMANT Julio J. Usera 177 Heritage Ln., Chatham, Mass		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. 5789 IMMEDIATE CAUSE (a). GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 25 DECEMBER 19 81, to 21 JANUARY 19 82, that (I) (we) lost saw the deceased alive on 21 JANUARY 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE K. Lee		DEGREE		22c. DATE SIGNED 1-22-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. LEE, LT, MC, USNR		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 1/23/82		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. REGISTRAR'S SIGNATURE JAN 28 1982			
24. FUNERAL DIRECTOR NAME DeVol Funeral Home Inc. Washington, D.C.		25. REGISTRAR'S SIGNATURE JAN 28 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Level General Home Inc. Washington, D.C.  
Metropolitan Opera House, Virginia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 7 5			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Beatrice Vargiu</i>				2a. DATE OF DEATH MONTH DAY YEAR 1-31-82			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR 5 8 1900		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Egypt</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY COUNTY</i> MD	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13e. STREET ADDRESS <i>1401 Blair Mill Road</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Giacomo Vargiu</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Orsini</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Unkn.</i>		16b. SOCIAL SECURITY NO. <i>546-59-6137</i>		17. INFORMANT ADDRESS <i>711 Justin Way, Silver Spring, James Vargiu, Son, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1749 CARCINOMA OF BREAST</i> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>1749</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/27</i> , 19 <i>81</i> , to <i>1/31</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>1/29</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kierland C. Brace</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>2/1/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kierland C. Brace</i>				22e. ADDRESS <i>17600 Cullen Ave Takoma Park, Md 20912</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>2-10-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland, P.G., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Robt E Wilhelm</i> ADDRESS <i>4308 Suitland Rd., Suitland, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 16 1982</i>		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	



WASHINGTON COUNTY

Washington Advertising House.

Tolson, Frank

1901 Main Mill Road

Silver Spring

MD.

544-22-6117

Under.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Linnie F. Vaughn</b>					8 2 0 2 3 7 6 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Linnie F. Vaughn</b>					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>1 1 82 10 29 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 6, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN CO. (HRS.)) <b>Newbern, Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (OF HOSPITAL OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (CITY OR TOWN) COUNTY <b>D.C.</b> MONTGOMERY					13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>314 East Capitol Street</b>		
14. FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>William Jefferson Flatt</b>					15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Bettie Lambert</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Washington, D.C. 20003</b>		17. INFORMANT <b>Dr Edward B. Lewis-Pastor 401-Seward Sq. S.E.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1991</b> IMMEDIATE CAUSE (a) <b>Bacterial Pneumonia / Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Adenocarcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Perforated Diverticulitis &amp; Congestive Heart Failure</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12-17, 19 81</b> , to <b>1-1, 19 82</b> , that (I) (we) lost saw the deceased alive on <b>12-31, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Steven A. Burger</b> MD					22c. DATE SIGNED <b>1-4-82</b>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Steven A. Burger</b>	
22e. ADDRESS <b>2101 Medical Park Dr Silver Spring, Md.</b>					22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 6, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Newbern, Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Newbern, Tenn.</b>			
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002</b>					25a. RECEIVED BY RETURN MAIL <b>JAN 6 1982</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 0 2 3 7 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <i>Simonea P. Vehmemente</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>1-25-82</i> 2b. HOUR <i>05 9 A M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>June 20, 1912</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i>		7. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Philippines</i>		9b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Mont.</i>		13c. STREET ADDRESS <i>101 Odend'Hal Ave</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Atanacio Paguyo</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Cristina Barrera</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>None</i>	
16b. SOCIAL SECURITY NO. <i>212 88 9767</i>		17. INFORMANT ADDRESS <i>Eugenio C. Vehmemente (Husband) Same as 13E</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>massive Cerebro-vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4360</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pneumonia, malnutrition</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>25 Dec 82</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <i>25 Dec 82</i> to <i>24 Jan 82</i> , that (I) (we) lost saw the deceased alive on <i>24 Jan 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Eugenio C. Vehmemente, MD</i> DEGREE <i>MD</i>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CORAZON C. LATIRI MD</i>		22d. ADDRESS <i>10911 Stonyhill St S.S. Md 20901</i>		22e. DATE SIGNED <i>25 Jan 82</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/28/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>S.S. Mont. Maryland</i>		24. FUNERAL DIRECTOR <i>Hines/Rinaldi F.H. 11800 N.H. Ave. S.S. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 28 1982</i>	
25b. REGISTRAR'S SIGNATURE <i>Francis J. Nathan</i>					

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*[Faint, illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02373	
1. DECEASED NAME (TYPE OR PRINT) <b>Edward S. Vermillion</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 4 1982</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 4 1921</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>60 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>Jan 4 1982</b>		2b. HOUR <b>1000</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TOOL &amp; DIE MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GPO</b>			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2919 Kingwood Ct.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD C. VERMILLION</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SYDNEY KIRTLEY</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>579-14-1139</b>		17. INFORMANT ADDRESS <b>BETTY L. VERMILLION SAME AS 13 WIFE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Chronic Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4291</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D.</b>		MEDICAL EXAMINER				DATE SIGNED <b>Jan 5, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/8/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>			

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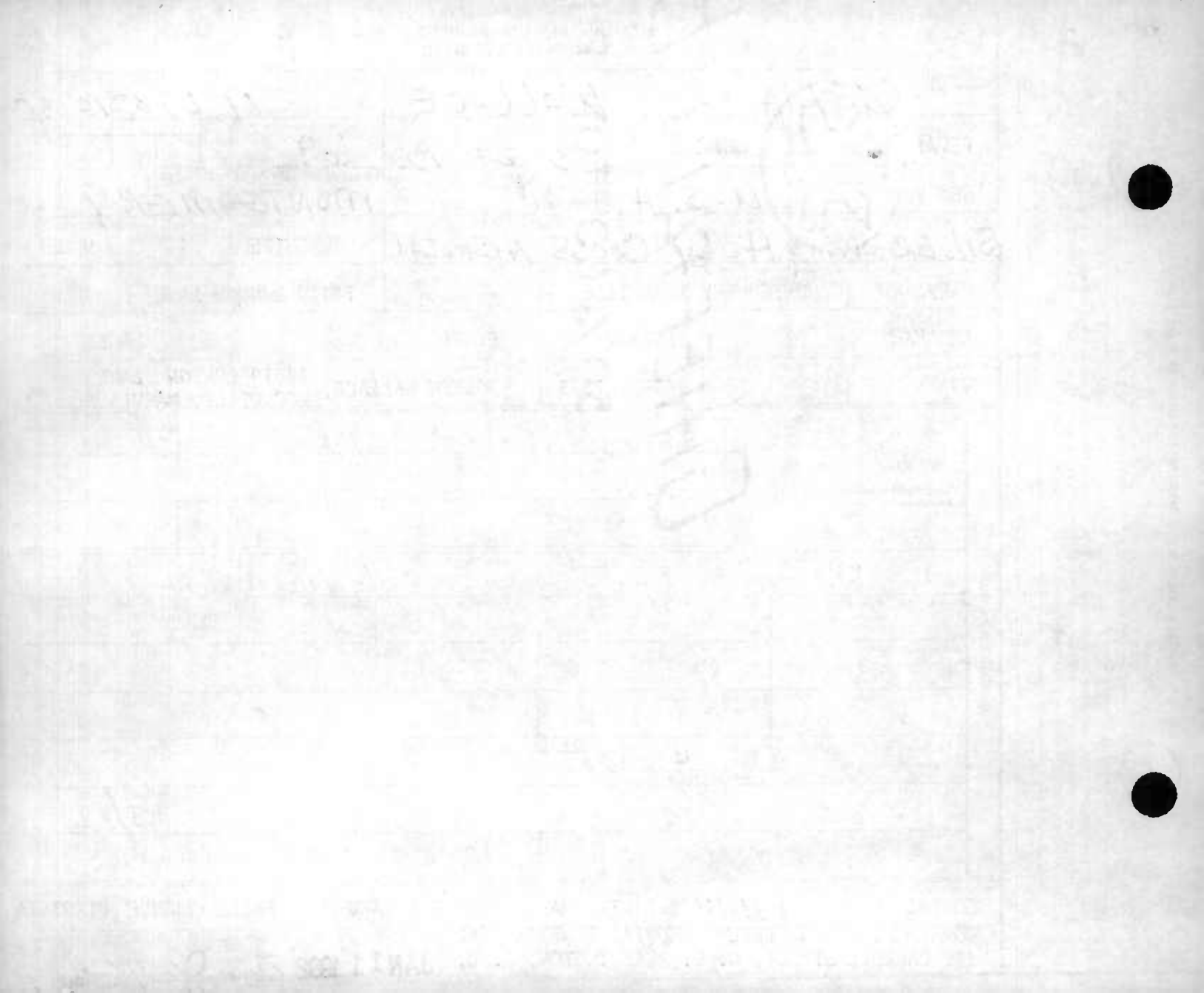


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 7 9			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 01 05 82 2:05 PM			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CELIA WALLACE				2b. HOUR			
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3 27 12		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME (TYPE OR PRINT) FIRST MIDDLE ABRAHAM ELKIND		15. MOTHER'S MAIDEN NAME (TYPE OR PRINT) FIRST MIDDLE ETHEL HAGER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO		16b. SOCIAL SECURITY NO. 083-01-1333	
16c. NO OR UNKNOWN (IF YES, GIVE WAR OR DATES)		17 INFORMANT JOSEPH WALLACE, 14019 LONDON LANE, ROCKVILLE, MARYLAND		17a. ADDRESS		17b. CITY OR TOWN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock / Cardiac Arrest 0389 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1. Atherosclerosis, Heart Disease 2. Diabetes mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 1, 19 82, to January 5, 19 82, that (I) (we) last saw the deceased alive on January 4, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE David B. Duman, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David B. Duman, M.D.		22e. ADDRESS 1106 Spring Street Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/7/1982		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION OR TOWN FALLS CHURCH, VIRGINIA	
24. FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR JAN 11 1982		25b. REGISTRAR'S SIGNATURE			
24. NAME 232 CARROLL STREET, N. W., WASHINGTON, D. C.							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX				4. RACE			
Anna H. Wallner		Female				White			
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			
MONTH DAY YEAR		71 YRS.				Hungary			
07 29 10		71				USA			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH			
		Montgomery				Silver Spring			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Holy Cross Hospital		Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6111 Montrose Road, Apt 822	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					
Joseph Schwarzw		Serena Klein		No					
16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c)					
579-40-5547D		Frances Greenwood		Intracerebral Hemorrhage					
		9909 East Light Drive, Silver Spring, Md. 20903		2030					
				DUE TO, OR AS A CONSEQUENCE OF					
				(b) Thrombocytopenia					
				DUE TO, OR AS A CONSEQUENCE OF					
				(c) Multiple Myeloma					
				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I					
				Arteriosclerotic cardiovascular disease. Diabetes mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from June 19 79, to Jan 7 19 82, that (I) (we) lost saw the deceased alive on Jan 8 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
Morton C. Altshuler M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1-5-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Morton Altshuler M.D.		1299-14 Montrose Dr. Silver Spring, Md. 20903							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/11/1982		King David Mem. Garden		Falls Church, Virginia			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		JAN 12 1982				Frances Jean Nathan			





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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02381	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James Gates Warren</b>										2a. DATE KNOWN OF ESTI. DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1/6 19 82</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Aug. 12, 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>58 YRS.</b>		IF UNDER 1 YR. IF UNDER 24 HRS. HOURS MIN.		2b. DATE PRONOUNCED DEAD <b>1/6 19 82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>				10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10921 Inwood Avenue, #224</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unk</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Unk</b>				13a. STATE <b>Maryland</b>			
13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>10921 Inwood Avenue, #224</b>				14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeremiah P Warren</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna n/a Gates</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11</b>				17. DECEASED ADDRESS <b>421 Hapers Ferry Rd. Bingham, Ala</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) Carcinoma of lung.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>1/6/82</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-8-1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>S. Sp. WW Chambers Co.</b>						ADDRESS <b>8655 Georgia Ave</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 13 1982</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) TOD HOWARD WATERS					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 4, 1982				
3 SEX MALE					2b. HOUR 11:20am				
4 RACE CAUC					6. AGE (IN YEARS LAST BIRTHDAY) 23				
5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 1, 1958					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT					9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.				
7b. CITIZEN OF WHAT COUNTRY? USA					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACTIVE DUTY				
10. CITY OR TOWN OF DEATH BETHESDA					12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER					13a. STREET ADDRESS 1046 DALEBROOK DRIVE ALEXANDRIA, VIRGINIA 22308				
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE VIRGINIA					13b. CITY OR TOWN ALEXANDRIA				
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS 1046 DALEBROOK DRIVE ALEXANDRIA, VIRGINIA 22308				
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT GEORGE WATERS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE STEPHENSON				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. 1979-1982				
17. INFORMANT 1046 DALEBROOK DRIVE ROBERT WATERS: ALEXANDRIA, VA. 22308									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1991</u> <u>METASTATIC CARCINOMA WITH PLEURAL EFFUSION</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>08 SEPTEMBER</u> 19 <u>81</u> to <u>04 JANUARY</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>04 JANUARY</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>G. S. Sladek</u> DEGREE _____ 22c. DATE SIGNED <u>1/5/82</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. SLADEK, LCDR, MC, USNR									
22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER, BETHESDA, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial									
23b. DATE Jan/7/82									
23c. NAME OF CEMETERY OR CREMATORY Arlington National									
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Va.									
24. FUNERAL DIRECTOR NAME ADDRESS Chambers Funeral Home Silver Spring, Md.									
25a. DATE RECEIVED BY REGISTRAR JAN 11 1982									
25b. REGISTRAR'S SIGNATURE <u>Frances Jan Nathan</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 8 3	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>CALVIN ARTHUR WATSON</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 30, 1982</b>			2b. HOUR <b>5:30 a.m.</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 11, 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kansas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE CLINICAL CENTER, NIH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Director DAVA Communications</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joel W. Watson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Remley</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWII 514-14-9179</b>		17. INFORMANT ADDRESS <b>MRS. SYLVIA WATSON (NOK)</b>			18. SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CACHEXIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>METASTATIC ESOPHAGEAL CARCINOMA</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>WEEKS</b> <b>6 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 21, 1981</b> to <b>JANUARY 30, 1982</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 30, 1982</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did not see) the body after death.											
22b. SIGNATURE <i>Carl A. Patow</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>30 Jan 82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARL A. PATOW M.D.</b>			22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Jan. 31, 1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria Virginia</b>			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1982</b>		25b. REGISTRAR'S SIGNATURE <i>Thomas J. [Signature]</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in your office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 8 2 0 2 3 8 4						
1. DECEASED NAME (TYPE OR PRINT) <b>Howard E Way</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 29 82</b>			2b. HOUR <b>8:15am</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 10 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Industrial Spec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Commerce</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chase</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry P. Way</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Prough</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW1</b>		17. INFORMANT ADDRESS <b>Ellen Way. Same as item 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ORGANIC BRAIN SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 MONTH</b> <b>YRS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 19 75</b> to <b>JAN 29 82</b> , that (I) (we) last saw the deceased alive on <b>JAN 29 19 82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel Rosenblum</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/29/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL ROSENBLUM</b>		22e. ADDRESS <b>10400 CONNECTICUT AV KENSINGTON, MD 20855</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph G. Waler's Sons Inc.</b> ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1982</b> REGISTRAR'S SIGNATURE <b>Frances Jan Thelton</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 8 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Charlotte A. Webster</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 15 '82</b>		2b. HOUR <b>1132<sup>AM</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 11, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Manufacturing</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13e. STREET ADDRESS <b>301 Russell Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward M. Webster</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Gonzo</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-20-8382</b>		17. INFORMANT ADDRESS <b>Wilson Health Care Center Records 301 Russell Avenue, Gaithersburg, Md. 20877</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7 days yema</b>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>SEMI LIT</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 45</b> to <b>1/15/82</b> , that (I) (we) last saw the deceased alive on <b>1/15/82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.				22b. SIGNATURE <b>Thos G. Ward</b> DEGREE		22c. DATE SIGNED <b>1/15/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>		22e. ADDRESS <b>6116 Robinson Bethesda 20817</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/17/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rocky Springs Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Fred. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Gartner Sandison F. H.</b>		ADDRESS <b>316 E. Diamond Ave. Gaithersburg, Md. 20877</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1982</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Jan Nathan</b>	

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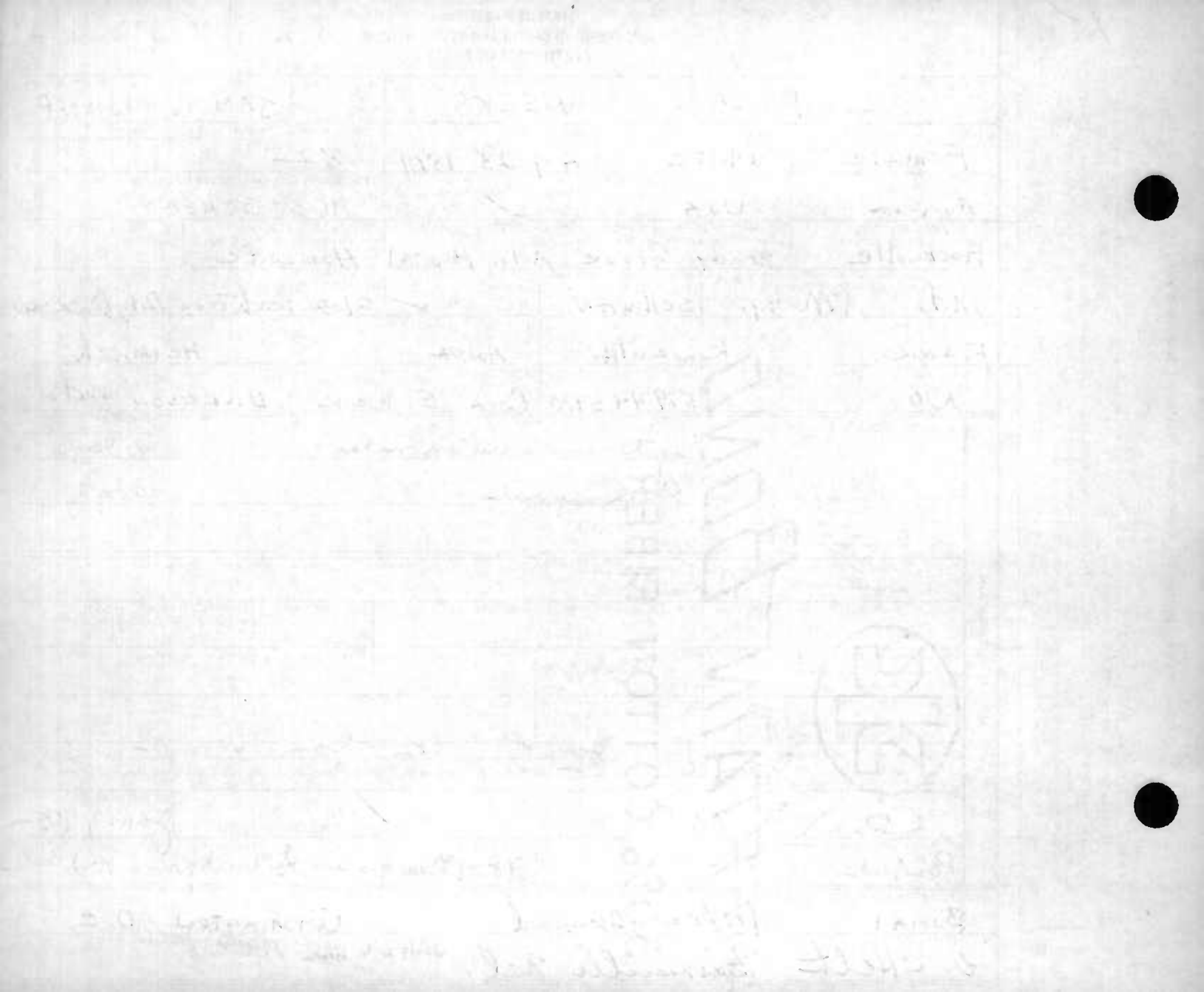
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 8 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>LUDMILLA - WEEKS</u>				2a. DATE OF DEATH MONTH <u>JAN</u> DAY <u>16</u> YEAR <u>1982</u> 2b. HOUR <u>11:25 P.M.</u>			
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH <u>Aug</u> DAY <u>23</u> YEAR <u>1899</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>82</u> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Austria</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD	
10. CITY OR TOWN OF DEATH <u>Rockville</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Shady Grove Adv. Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>md.</u> 13b. COUNTY <u>Montg.</u> 13c. CITY OR TOWN <u>Sellman</u>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <u>21030 Peach Tree Rd., Dickerson</u>			
14. FATHER'S NAME FIRST <u>Frank</u> MIDDLE <u>Kowanda</u> LAST <u>Heimisch</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Anna</u> MIDDLE <u>Heimisch</u> LAST <u>Heimisch</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>579 44 5470</u>		17. INFORMANT <u>Cora E. Week</u> ADDRESS <u>Dickerson Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>5908</u> IMMEDIATE CAUSE (a) <u>Septicemic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Anoxia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 days</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <u>Cerebral Anoxia</u>							
19a. DATE OF OPERATION <u>Jan 17</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>82</u> , to <u>Jan 16</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Jan 16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>[Signature]</u> M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Jan 17, 1982</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BLAINE H. EIG</u>		22e. ADDRESS <u>9801 George Ave Silver Spring, Md 20902</u>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <u>Burial</u>		23b. DATE <u>1/19/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		23d. LOCATION CITY OR TOWN <u>Washington</u> COUNTY <u>D.C.</u> STATE <u>D.C.</u>	
24. FUNERAL DIRECTOR NAME <u>Wepelt</u> ADDRESS <u>Barnsville Md.</u>		25. DATE REC'D. BY REGISTRAR <u>JAN 20 1982</u>		26. SIGNATURE OF REGISTRAR <u>[Signature]</u>			

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <b>Edith V. Weigert</b>									
1. DECEASED NAME (TYPE OR PRINT) <b>Edith V. Weigert</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>12</b> YEAR <b>82</b> 2b. HOUR <b>5P</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>6</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Beth. Retirement &amp; Nursing Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Physician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Psychiatrist</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12 Oxford St.</b>	
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216-38-6253</b>		17. INFORMANT ADDRESS <b>Wash., D.C.</b> <b>Wolfgang Weigert 3545 Ordway St. N.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cessation heart</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>myocardial infarct</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis heart</b> Approximate interval between onset and death <b>5 min</b> <b>24 hrs</b> <b>20 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/11/82</b> , 19 <b>82</b> , to <b>1/12/82</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1/11/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Milton Gusack, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/12/82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Milton Gusack, M.D.</b>						22e. ADDRESS <b>2201- L, NW Wash DC 20037</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/15/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN <b>Suitland, Md.</b> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wis. Av. N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1982</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Jean Nathan</b>			



With V. agent

Female

White

Feb. 6, 1904

Montgomery

x

Is

Montgomery

Cherry Chase

Beth. Notingham & Loring Cr.

Physician

Physician

No.

Montgomery

Cherry Chase

x

12 Oxford St.

Unknown

Unknown

Unknown

Unknown

No

210-2-222

Notingham & Loring Cr.

210-2-222

210-2-222

Transmission 1/12/82  
Foreign Quarter's News, Inc.  
2100 1st St. N.E. Wash., D.C.

Cedar Hill Cemetery  
Baltimore, Md.

JAN 21 1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR				REG. NO. 8 2 0 2 3 8 8					
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
Paul Henry Werres				January 21, 1982				8:50 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR	
Male		White		July 7, 1907		74		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		USA				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		The Clinical Center, NIH				Executive		Manufacturing	
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland				Montgomery		Chevy Chase		4701 Willard Avenue #1014	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Henry P. Werres				Mary -- Rohrer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				577-09-6479		Elizabeth Ravenscroft, daughter, 10245 Gainsborough, Potomac, Md.			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
2000 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia</u>									1 week
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diffuse histocytic lymphoma</u>									1979
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Central nervous system involvement with lymphoma</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>6 January</u> 19 <u>82</u> to <u>21 January</u> 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>21 January</u> 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (do) (do) view the body after death									
22b. SIGNATURE			22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS			22e. DATE SIGNED
<u>E. Reed, MD</u>			Eddie Reed, MD			The Clinical Center, National Institutes of Health, Bethesda, Md			1/22/82
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			1-25-82		Gate of Heaven Cem.		Silver Spring-Montgomery-Md.		
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Inc.</u> NAME ADDRESS 5130 Wisconsin Avenue, N.W.-Washington, D.C.						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 27 1982 <u>Frances Jean Nathan</u>			

WASHINGTON, D.C.



Washington, D.C.  
The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the act of March 3, 1879, entitled "An Act to provide for the better management of the public lands, and for other purposes."

Henry  
No  
The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the act of March 3, 1879, entitled "An Act to provide for the better management of the public lands, and for other purposes."

General  
The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the act of March 3, 1879, entitled "An Act to provide for the better management of the public lands, and for other purposes."

1-25-02  
The following is a list of the names of the persons who have been appointed to the various positions in the Department of the Interior, under the act of March 3, 1879, entitled "An Act to provide for the better management of the public lands, and for other purposes."

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE H. LAST Wesley					2a. DATE OF DEATH MONTH DAY YEAR 1/15/82				
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 22, 1887		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7b. HOUR 7:45 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY P.G. Co.		13c. CITY OR TOWN Upper Marlboro		13d. STREET ADDRESS 9184 Old Burton Circle			
14. FATHER'S NAME FIRST MIDDLE LAST Daniel H. Mudd					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Benson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Patricia E. Whitman Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5990 Acute Pneumonia Right & Left lower lobes DUE TO, OR AS A CONSEQUENCE OF (b) Acute Urinary Tract Infection DUE TO, OR AS A CONSEQUENCE OF (c) Acute Pulmonary Edema APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/82 1/82 1/82									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a CMA, ASCVD, Atrial fibrillation									
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 1/14/82 to 1/15/82, that (I) saw the deceased alive on 1/14/82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death.									
22b. SIGNATURE MB Patuck MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GB Patrick MD					22e. ADDRESS 2221 Colville Rd Silver Spring, Md 20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan/18/81		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Church		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel, P.G. Co., Maryland			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home Riverdale, Maryland					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 20 1982 Patricia E. Whitman				

UNITED STATES DEPARTMENT OF THE ARMY

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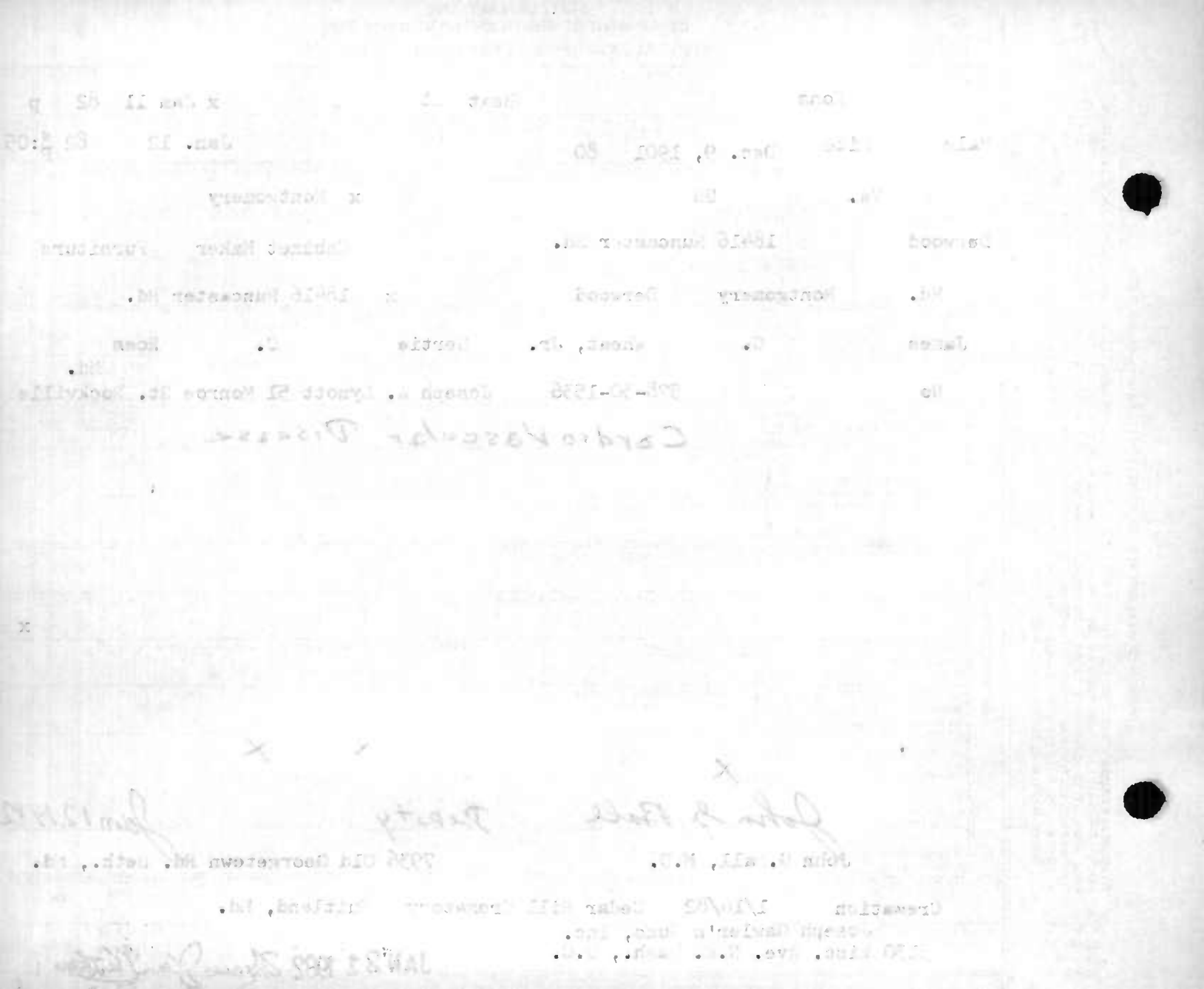
10/11/00

10/11/00

12

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02390	
1. DECEASED NAME (TYPE OR PRINT) <b>Ross</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 11 1982</b>		2b. HOUR <b>p</b>		2c. DATE PRONOUNCED DEAD <b>Jan. 12 1982</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 9, 1901</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>80 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. HOURS MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>US</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Derwood</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>18416 Muncaster Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cabinet Maker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>	
13a. STATE <b>Md.</b>			13b. CITY <b>Montgomery</b>		13c. CITY OR TOWN <b>Derwood</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>18416 Muncaster Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>James C. Wheat, Jr.</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertie C. Ross</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>678-30-1536</b>			17. INFORMANT ADDRESS <b>Joseph A. Lynott 51 Monroe St. Rockville Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CardioVascular Disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John B. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				DATE SIGNED <b>Jan 12, 1982</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>7936 Old Georgetown Rd. Beth., Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1/16/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>JAN 21 1982</b>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 9 1			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Patricia A. Wiener</b>				2a. DATE OF DEATH MONTH DAY YEAR 2b HOUR <b>1 9 82 9 A M</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 18 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>53</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co MD.</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary -</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PEPCO</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Lanham</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Raymond Terry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Beasley</b>		13e. STREET ADDRESS <b>9001 3rd. St.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>578-36-8613</b>		17. INFORMANT ADDRESS <b>Aubrey R. Wiener - above address</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis peritonei</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1539</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mon.</b> <b>1 yr.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-03-82</b> , 19 <b>82</b> , to <b>Jan 9</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>Jan 8</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Harold S. Tidler</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-9-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nalley's F.H. Inc.</b>				22e. ADDRESS <b>Mt. Rainier, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/12/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1982</b>			
				25b. REGISTRAR'S SIGNATURE <b>Thomas J. [Signature]</b>			

MEDICAL CERTIFICATION

Sample	Area	Yield	Structure	Formula	Weight
1	10.5	10.5	10.5	10.5	10.5
2	10.5	10.5	10.5	10.5	10.5
3	10.5	10.5	10.5	10.5	10.5
4	10.5	10.5	10.5	10.5	10.5
5	10.5	10.5	10.5	10.5	10.5
6	10.5	10.5	10.5	10.5	10.5
7	10.5	10.5	10.5	10.5	10.5
8	10.5	10.5	10.5	10.5	10.5
9	10.5	10.5	10.5	10.5	10.5
10	10.5	10.5	10.5	10.5	10.5
11	10.5	10.5	10.5	10.5	10.5
12	10.5	10.5	10.5	10.5	10.5
13	10.5	10.5	10.5	10.5	10.5
14	10.5	10.5	10.5	10.5	10.5
15	10.5	10.5	10.5	10.5	10.5
16	10.5	10.5	10.5	10.5	10.5
17	10.5	10.5	10.5	10.5	10.5
18	10.5	10.5	10.5	10.5	10.5
19	10.5	10.5	10.5	10.5	10.5
20	10.5	10.5	10.5	10.5	10.5
21	10.5	10.5	10.5	10.5	10.5
22	10.5	10.5	10.5	10.5	10.5
23	10.5	10.5	10.5	10.5	10.5
24	10.5	10.5	10.5	10.5	10.5
25	10.5	10.5	10.5	10.5	10.5
26	10.5	10.5	10.5	10.5	10.5
27	10.5	10.5	10.5	10.5	10.5
28	10.5	10.5	10.5	10.5	10.5
29	10.5	10.5	10.5	10.5	10.5
30	10.5	10.5	10.5	10.5	10.5
31	10.5	10.5	10.5	10.5	10.5
32	10.5	10.5	10.5	10.5	10.5
33	10.5	10.5	10.5	10.5	10.5
34	10.5	10.5	10.5	10.5	10.5
35	10.5	10.5	10.5	10.5	10.5
36	10.5	10.5	10.5	10.5	10.5
37	10.5	10.5	10.5	10.5	10.5
38	10.5	10.5	10.5	10.5	10.5
39	10.5	10.5	10.5	10.5	10.5
40	10.5	10.5	10.5	10.5	10.5
41	10.5	10.5	10.5	10.5	10.5
42	10.5	10.5	10.5	10.5	10.5
43	10.5	10.5	10.5	10.5	10.5
44	10.5	10.5	10.5	10.5	10.5
45	10.5	10.5	10.5	10.5	10.5
46	10.5	10.5	10.5	10.5	10.5
47	10.5	10.5	10.5	10.5	10.5
48	10.5	10.5	10.5	10.5	10.5
49	10.5	10.5	10.5	10.5	10.5
50	10.5	10.5	10.5	10.5	10.5
51	10.5	10.5	10.5	10.5	10.5
52	10.5	10.5	10.5	10.5	10.5
53	10.5	10.5	10.5	10.5	10.5
54	10.5	10.5	10.5	10.5	10.5
55	10.5	10.5	10.5	10.5	10.5
56	10.5	10.5	10.5	10.5	10.5
57	10.5	10.5	10.5	10.5	10.5
58	10.5	10.5	10.5	10.5	10.5
59	10.5	10.5	10.5	10.5	10.5
60	10.5	10.5	10.5	10.5	10.5
61	10.5	10.5	10.5	10.5	10.5
62	10.5	10.5	10.5	10.5	10.5
63					

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END

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by a attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove certificates, pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or inhumation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 0 2 3 9 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>MYRTLE S WILCOX</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 19 82</b>				2b. HOUR <b>5 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 6 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philadelphia Pa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>GAITHERSBURG</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ASBURY METHODIST HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PIANO TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>TEACHER</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>M.D.</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>POTOMAC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12 Deborah Ct. Potomac Md.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WALTER - SMITH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY - ALBURGER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>-</b>		16c. ADDRESS <b>Wilson Health Care Center Records</b>		16d. ADDRESS <b>301 Russell Ave., Gaithersburg, Md. 20877</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4360 Acute C.V.A. (Cerebro Vascular Accident)</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 18 1980</b> to <b>Jan 19 1982</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>Dec 9 1981</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <b>Robert T. Thibadeau</b>				DEGREE <b>ATTENDING PHYSICIAN</b>				22c. DATE SIGNED <b>1-19-82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT T. THIBADEAU</b>				22e. ADDRESS <b>ROUVILLE, MD. 20852</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/23/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Peace Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Philadelp. Philadelphia Pa.</b>			
24. FUNERAL DIRECTOR NAME <b>Turner Funeral Home</b>				6028 Ridge Avenue, Philadelphia, Pa. 19128		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>					

DAVID WILKINSON

WILKINSON

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WILKINSON, DAVID WILKINSON, 1011038800, 95815

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 9 3			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hilda May WILLIAMS				2a. DATE OF DEATH MONTH DAY YEAR January 29, 1982		2b. HOUR 3:30 A <sub>M</sub>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Germantown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24130 Ridge Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Montgomery Germantown				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 24130 Ridge Road	
14. FATHER'S NAME FIRST MIDDLE LAST Filmore C. Watkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Lydard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-32-2576		17. INFORMANT ADDRESS Mrs. Louise Mullinix Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MALIGNANT MELANOMA 1729 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY</u> , 19 <u>81</u> , to <u>JAN 28</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>JAN 26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Eugene P. Flannery		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Flannery, M.D.		22e. ADDRESS 18111 Prince Phillip Dr., Olney, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/82		23c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cedar Grove Montg. Md.	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A.		ADDRESS Damascus, Md.		25. BY REGISTRAR		26. BY REGISTRAR	

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0382 BP

RECEIVED NOV 10 1964

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or letterhead memorandum.]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN WILLIAMS</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>1 2 19 82</b>		2b. HOUR <b>M</b>
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 25, 1949</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>32</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sierra Leone</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Sierra Leone</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Cab driver</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Mont.</b>	13c. CITY OR TOWN <b>Takoma Park</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Agusta Williams</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Holloway</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-80-3484</b>		17. INFORMANT <b>6001 Logan Way, Momo Kamara-cousin-Bladensburg, Md. 20781</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>JRSuaw</b>		TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>1/4/82</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>		ADDRESS <b>111 Penn Street, Balto. MD 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 18-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Makent</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>		ADDRESS <b>11800 N.H. Ave. S.S. Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1982</b>	
25b. REGISTRAR'S SIGNATURE <b>Francis J. Thornton</b>					



1972-02-28

*Handwritten signature*

1972-02-28  
JAN 15 1972  
MAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 0 2 3 9 5			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Joseph Edward Williams</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 15, 1982</b>		2b. HOUR <b>5:10A M</b>	
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 18 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>79</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dep. Asst. Atty Gen.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Dept. Justice</b>	
13a. STATE <b>Md.</b>				13b. CITY OR TOWN <b>Mont</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph A Williams</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna W. Wilkinson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-60-0263</b>		17. INFORMANT ADDRESS <b>Beverly Moffett, 1501 Penna. Ave., N.W. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIOSCLEROSIS, CEREBRAL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS, GENERALIZED</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 YEAR</b> <b>3 YRS.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9:30</b> , 19 <b>81</b> , to <b>1:15</b> , 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>1:14</b> , 19 <b>82</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.							
22b. SIGNATURE <b>Frank G. Mac Murray, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>Jan. 15, 1982</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frank G. Mac Murray</b>				22e. ADDRESS <b>3301 New Mexico Ave., NW, Washington, D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/22/1982</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Mac Murray</b>	
25c. ADDRESS <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>							

7150 Race Ave., N.W., Wash., D.C.  
Gordon Lawler's Sons Inc.  
April 1/25/1962  
Bucklin Memorial Park Com. Rockville Md.

Frank G. Mac Murray  
3501 New Mexico Ave., N.W., Washington, D.C.

Jan. 15, 1962



X

277-60-0553 Beverly Horstett. 1501 Penna. Ave., N.W., D.C.

Joseph A. Williams  
Chevy Chase Md.

4630 River Road

Carriage Hill Nursing Home  
U.S.A.A. 79

Joseph Edward Williams  
Jan. 15, 1962 2:10A

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 9 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Arthur</b>		FIRST <b>Francis</b>		LAST <b>Wilson</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>January 1, 1982</b>				2b. HOUR <b>2:57P</b> M	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 25 C3</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>38X 78</b> YRS				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRINTER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. CITY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6431 SOUTH LEISURE WORLD BLVD.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK WILSON</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CECILE SCHOBEL</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>451-05-4861</b>		17. INFORMANT ADDRESS <b>DOROTHY S. WILSON SAME AS 13e</b>				WIFE			
18. CAUSE OF DEATH: Enter only one cause per part. Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cholelithiasis and pancreatitis</b> (c) <b>Myocardial infarction</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										CHECKMATE INTERVAL BETWEEN CAUSE AND DEATH <b>1 hr</b> <b>1 hr</b> <b>to home</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>1/1/82</b> , 19 <b>82</b> , to <b>1/1</b> , 19 <b>82</b> , that (I) (we) lost saw the deceased alive on <b>1/1/82</b> , 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>D.R. Schuber MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/2/82</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D.R. Schuber MD</b>				22e. ADDRESS <b>17904 Georgia Ave #46 Olney Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>1-4-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD P.G. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>				500 UNIVERSITY BLVD. WEST, SILVER SPRING, MD				25a. DATE REC'D. BY REGISTRAR <b>JAN 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>	

MEDICAL CERTIFICATION

52



421-02-1881 GORDON S. WILSON SAFE 22 136  
WILSON  
TELE  
MONTGOMERY STILES SPOT  
WILSON  
6431 SOUTH LESTER ROAD  
WILSON

FRANCIS J. COLLINS  
STILES STREET  
JAN 8 1965  
WESTWOOD 2.0  
1-4-65  
LINCOLN CENTER  
WESTWOOD 2.0  
1-4-65

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 0 2 3 9 7	
1. DECEASED NAME (TYPE OR PRINT) <b>(Louis) Lewis Lexie Wilson</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>January</b> DAY <b>1/30</b> YEAR <b>19 82</b>		7b. HOUR <b>12:10 P.</b>			
3. SEX <b>Male</b>	4. RACE <b>Black</b>	5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>1</b> YEAR <b>1929</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52 YRS.</b>	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>	IF UNDER 24 HRS. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD <b>January 1/30 19 82</b>		7c. HOUR <b>12:10 P.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1402 Morningside Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>private</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1402 Morningside Drive</b>			
14. FATHER'S NAME FIRST <b>Jervy</b> MIDDLE <b></b> LAST <b>Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Charlotte</b> MIDDLE <b></b> LAST <b>Wilson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>578 30 5097</b>		17. INFORMANT ADDRESS <b>Charlotte Wilson, mother, 900 G NE, Wash DC</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <b>arteriosclerotic cardiovascular disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>											
19a. DATE OF OPERATION <b>None</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>None</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b></b>		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John S. Rogers</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>2/1/82</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>			ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/5/82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cem.</b>			23d. LOCATION CITY OR TOWN <b>Suitland, Maryland</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Alexander S. Pope</b> ADDRESS <b>2617 Pennsylvania Ave., S.E.</b>					25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1982</b>		25b. REGISTRAR'S SIGNATURE <b></b>				

100% COTTON FIBER  
MADE IN U.S.A.

*[Handwritten signature]*

James E. Page, 117 Pennsylvania Ave.,  
Philadelphia, Pa.



BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 3 9 8			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Jane Winpiger</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>January 7, 1982</i>				2b. HOUR <i>2:30 PM</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 14 1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>59</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Gov't</i>					
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>		13c. CITY OR TOWN <i>Frederick</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>8101 Runny Meade Dr.</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>James G. Arbaugh</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Martha F. Fike</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-18-7732</i>		17. INFORMANT ADDRESS <i>Charles A. Winpiger Meade Dr.</i>									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sepsis candida tropicalis</i> <i>2028</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lymphoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Acute renal failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION <i>12/18/81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>exploration of flank</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/81</i> , 19 <i>81</i> , to <i>1/7</i> , 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE DEGREE <i>Kaldun Nossuli MD</i> MD						22c. DATE SIGNED <i>1/8/82</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KALDUN NOSSULI MD</i>						22e. ADDRESS <i>11500 old glenbrook rd Rockville MD 20852</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>1/10/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Resthaven Mem. Gar.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Frederick Jdk. Md.</i>							
24. FUNERAL DIRECTOR NAME <i>E. Douglas Stuffer</i>						24b. ADDRESS <i>Frederick Md.</i>		25a. RECEIVED BY REGISTRAR 25b. RECEIVED BY REGISTRAR					

512

1997

Wiederholungsfragen: Wiederholungsfragen: Wiederholungsfragen

remains

217-10-7732 Charles A. Taylor

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 3 9 9

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Lester			Winstanley			January 7, 1982			8:15P M		
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		White		1 15 99			82 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
New Jersey		USA					Montgomery County MD.				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital					Supervisor			SEC	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
Maryland			Montgomery		Silver Spring				3642 Gleneagles Dr.		
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William Winstanley						Gertrude Stonier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
no				579-20-8694		Edith N. Winstanley Same as #13					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4278 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ventricular Tachycardia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Obstructive Pulmonary Disease</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>1/1</u> , 19 <u>82</u> to <u>1/7</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>1/7</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.											
22b. SIGNATURE <u>Dr. Daniel Goldberg</u>						DEGREE			22c. DATE SIGNED <u>1/8/82</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Daniel Goldberg						22e. ADDRESS 10401 Old Georgetown Rd - Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation			Jan. 9, 1982		Metropolitan			Alexandria Va.			
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Francis J. Collins 500 University Blvd. W., Silver Spring, Md.						JAN 12 1982			<u>Francis J. Collins</u>		



BP

DHMH - 16 50M 1/BI  
(VRA 15, 4)

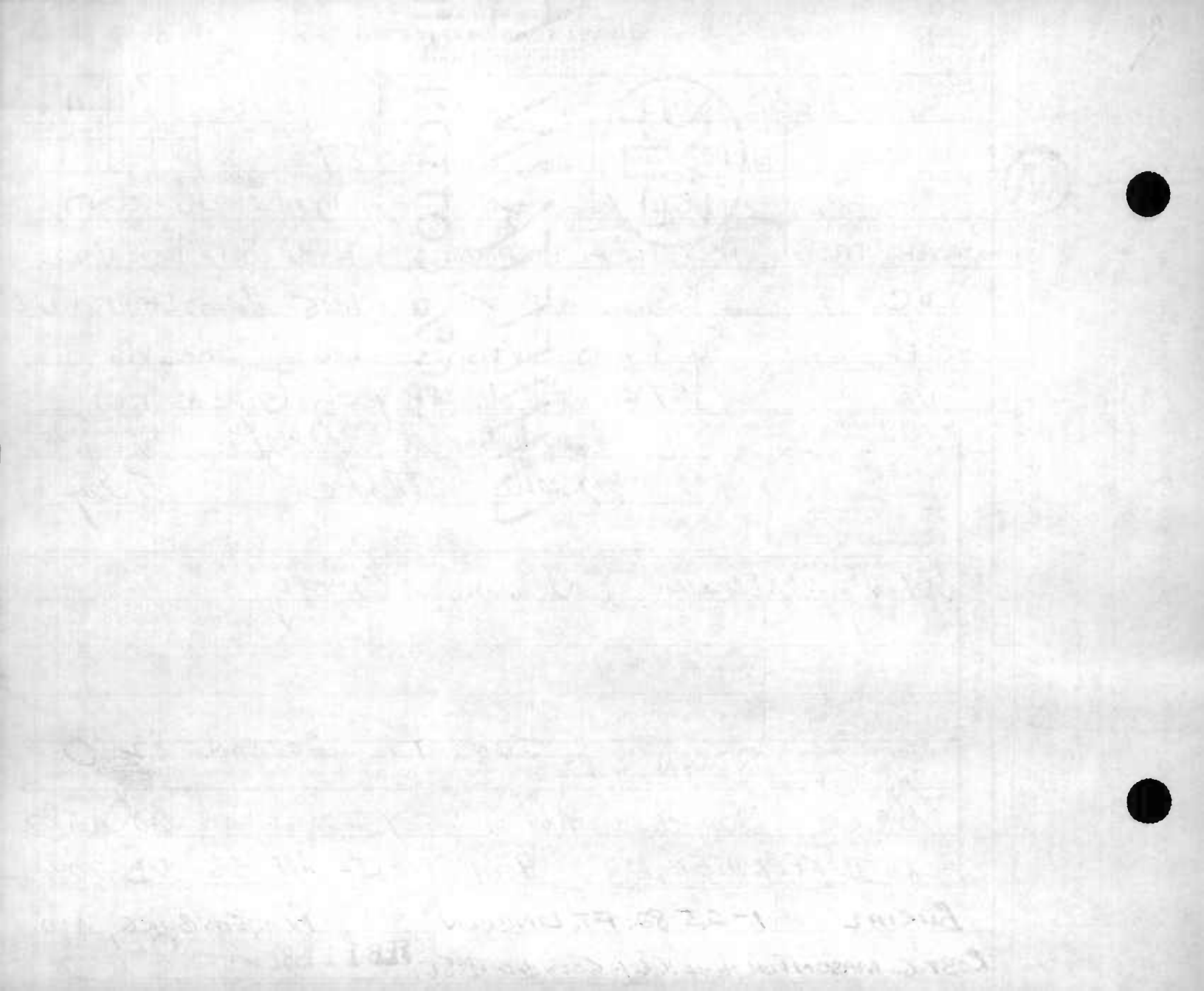
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health officer. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 0 2 4 0 0 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE YEARBY</b>										2a. DATE OF DEATH MONTH <b>1</b> DAY <b>20</b> YEAR <b>82</b>				2b. HOUR <b>11 A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH <b>AUG</b> DAY <b>31</b> YEAR <b>1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House W. Fe</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b> 13b. COUNTY <b></b> 13c. CITY OR TOWN <b>Washington</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <b>1005 HAMILTON ST. N.E.</b>					
14. FATHER'S NAME FIRST <b>Griff</b> MIDDLE <b></b> LAST <b>Williams</b>										15. MOTHER'S MAIDEN NAME FIRST <b>Vinnie</b> MIDDLE <b>Lou</b> LAST <b>Shields</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-38-682</b>		17. INFORMANT <b>Colquitt yearby (same as 13c)</b>											
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), (d), (e), (f), (g), (h), (i), (j), (k), (l), (m), (n), (o), (p), (q), (r), (s), (t), (u), (v), (w), (x), (y), (z), (aa), (ab), (ac), (ad), (ae), (af), (ag), (ah), (ai), (aj), (ak), (al), (am), (an), (ao), (ap), (aq), (ar), (as), (at), (au), (av), (aw), (ax), (ay), (az), (ba), (bb), (bc), (bd), (be), (bf), (bg), (bh), (bi), (bj), (bk), (bl), (bm), (bn), (bo), (bp), (bq), (br), (bs), (bt), (bu), (bv), (bw), (bx), (by), (bz), (ca), (cb), (cc), (cd), (ce), (cf), (cg), (ch), (ci), (cj), (ck), (cl), (cm), (cn), (co), (cp), (cq), (cr), (cs), (ct), (cu), (cv), (cw), (cx), (cy), (cz), (da), (db), (dc), (dd), (de), (df), (dg), (dh), (di), (dj), (dk), (dl), (dm), (dn), (do), (dp), (dq), (dr), (ds), (dt), (du), (dv), (dw), (dx), (dy), (dz), (ea), (eb), (ec), (ed), (ee), (ef), (eg), (eh), (ei), (ej), (ek), (el), (em), (en), (eo), (ep), (eq), (er), (es), (et), (eu), (ev), (ew), (ex), (ey), (ez), (fa), (fb), (fc), (fd), (fe), (ff), (fg), (fh), (fi), (fj), (fk), (fl), (fm), (fn), (fo), (fp), (fq), (fr), (fs), (ft), (fu), (fv), (fw), (fx), (fy), (fz), (ga), (gb), (gc), (gd), (ge), (gf), (gg), (gh), (gi), (gj), (gk), (gl), (gm), (gn), (go), (gp), (gq), (gr), (gs), (gt), (gu), (gv), (gw), (gx), (gy), (gz), (ha), (hb), (hc), (hd), (he), (hf), (hg), (hh), (hi), (hj), (hk), (hl), (hm), (hn), (ho), (hp), (hq), (hr), (hs), (ht), (hu), (hv), (hw), (hx), (hy), (hz), (ia), (ib), (ic), (id), (ie), (if), (ig), (ih), (ii), (ij), (ik), (il), (im), (in), (io), (ip), (iq), (ir), (is), (it), (iu), (iv), (iw), (ix), (iy), (iz), (ja), (jb), (jc), (jd), (je), (jf), (jg), (jh), (ji), (jj), (jk), (jl), (jm), (jn), (jo), (jp), (jq), (jr), (js), (jt), (ju), (jv), (jw), (jx), (jy), (jz), (ka), (kb), (kc), (kd), (ke), (kf), (kg), (kh), (ki), (kj), (kk), (kl), (km), (kn), (ko), (kp), (kq), (kr), (ks), (kt), (ku), (kv), (kw), (kx), (ky), (kz), (la), (lb), (lc), (ld), (le), (lf), (lg), (lh), (li), (lj), (lk), (ll), (lm), (ln), (lo), (lp), (lq), (lr), (ls), (lt), (lu), (lv), (lw), (lx), (ly), (lz), (ma), (mb), (mc), (md), (me), (mf), (mg), (mh), (mi), (mj), (mk), (ml), (mm), (mn), (mo), (mp), (mq), (mr), (ms), (mt), (mu), (mv), (mw), (mx), (my), (mz), (na), (nb), (nc), (nd), (ne), (nf), (ng), (nh), (ni), (nj), (nk), (nl), (nm), (nn), (no), (np), (nq), (nr), (ns), (nt), (nu), (nv), (nw), (nx), (ny), (nz), (oa), (ob), (oc), (od), (oe), (of), (og), (oh), (oi), (oj), (ok), (ol), (om), (on), (oo), (op), (oq), (or), (os), (ot), (ou), (ov), (ow), (ox), (oy), (oz), (pa), (pb), (pc), (pd), (pe), (pf), (pg), (ph), (pi), (pj), (pk), (pl), (pm), (pn), (po), (pp), (pq), (pr), (ps), (pt), (pu), (pv), (pw), (px), (py), (pz), (qa), (qb), (qc), (qd), (qe), (qf), (qg), (qh), (qi), (qj), (qk), (ql), (qm), (qn), (qo), (qp), (qq), (qr), (qs), (qt), (qu), (qv), (qw), (qx), (qy), (qz), (ra), (rb), (rc), (rd), (re), (rf), (rg), (rh), (ri), (rj), (rk), (rl), (rm), (rn), (ro), (rp), (rq), (rr), (rs), (rt), (ru), (rv), (rw), (rx), (ry), (rz), (sa), (sb), (sc), (sd), (se), (sf), (sg), (sh), (si), (sj), (sk), (sl), (sm), (sn), (so), (sp), (sq), (sr), (ss), (st), (su), (sv), (sw), (sx), (sy), (sz), (ta), (tb), (tc), (td), (te), (tf), (tg), (th), (ti), (tj), (tk), (tl), (tm), (tn), (to), (tp), (tq), (tr), (ts), (tu), (tv), (tw), (tx), (ty), (tz), (ua), (ub), (uc), (ud), (ue), (uf), (ug), (uh), (ui), (uj), (uk), (ul), (um), (un), (uo), (up), (uq), (ur), (us), (ut), (uu), (uv), (uw), (ux), (uy), (uz), (va), (vb), (vc), (vd), (ve), (vf), (vg), (vh), (vi), (vj), (vk), (vl), (vm), (vn), (vo), (vp), (vq), (vr), (vs), (vt), (vu), (vv), (vw), (vx), (vy), (vz), (wa), (wb), (wc), (wd), (we), (wf), (wg), (wh), (wi), (wj), (wk), (wl), (wm), (wn), (wo), (wp), (wq), (wr), (ws), (wt), (wu), (wv), (ww), (wx), (wy), (wz), (xa), (xb), (xc), (xd), (xe), (xf), (xg), (xh), (xi), (xj), (xk), (xl), (xm), (xn), (xo), (xp), (xq), (xr), (xs), (xt), (xu), (xv), (xw), (xx), (xy), (xz), (ya), (yb), (yc), (yd), (ye), (yf), (yg), (yh), (yi), (yj), (yk), (yl), (ym), (yn), (yo), (yp), (yq), (yr), (ys), (yt), (yu), (yv), (yw), (yx), (yy), (yz), (za), (zb), (zc), (zd), (ze), (zf), (zg), (zh), (zi), (zj), (zk), (zl), (zm), (zn), (zo), (zp), (zq), (zr), (zs), (zt), (zu), (zv), (zw), (zx), (zy), (zz)) <b>4360</b>										DUE TO, OR AS A CONSEQUENCE OF (a) <b>Cardiovascular Arrest</b> (b) <b>Stroke</b> (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>5 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Systemic hypertension unknown etiology</b>															
19a. DATE OF OPERATION <b>JUN 17 1982</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b></b>											
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>		21c. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>											
22a. I certify that (1) (this hospital) attended the deceased from <b>JUN 17 1982</b> to <b>JAN 20 1982</b> , that (1) (we) lost <b>20 JAN 1982</b> saw the deceased alive on <b>20 JAN 1982</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)															
22b. SIGNATURE <b>Alan J. Kermaier, M.D.</b>										22c. DATE SIGNED <b>20 Jan 82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN J. KERMAIER, M.D.</b>										22e. ADDRESS <b>9801 GEORGIA AVE. S.S. MD 20902</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-23-82</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d. LOCATION CITY OR TOWN <b>BLADENSBURG, MD.</b> COUNTY <b></b> STATE <b></b>									
24. FUNERAL DIRECTOR NAME <b>ROBT. G. MASON FUN. HOME</b> ADDRESS <b>1661 GOOD HOPE RD. S.E.</b>										25a. DATE REC'D. BY REGISTRAR <b>FEB 11 1982</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			





DISCUSSED & CARRIER + body released

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

3402

DMMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 0 2 4 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <del>XXXXXX</del> Elizabeth A. YILEK			2a. DATE OF DEATH MONTH DAY YEAR 1-25-82		2b. HOUR 5:40 P.M.
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 2-01-1900	6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY US Govt.
13a. STATE md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 13 204 Georgia Ave.
14. FATHER'S NAME FIRST MIDDLE LAST William Scott Ashlin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Talifarro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 524-09-1380		17. INFORMANT (executrix) ADDRESS Mildred B. Geagley (same ad 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): ASHD, mitral insufficiency					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-24-82 to 1-25-82, that (we) lost saw the deceased alive on 1-25-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE J. Kijak, Jr.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Kijak, JR.		22e. ADDRESS 344 University Blvd., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-28-1982	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Georges Md.
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		ADDRESS 1800 N.H. Ave., Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR JAN 28 1982	
25b. REGISTRAR'S SIGNATURE James J. Nathan					

MEDICAL CERTIFICATION

29



14

Wick Elizabeth

Female

9-11-18

1-22-82

Montgomery County

Rockville Shady Grove Hospital

and Montgomery Hospital

25-02-18

22-02-18

22-02-18

22-02-18

22-02-18

22-02-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



BP

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO. 8 2 0 2 4 0 2									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIE (NMN) YOUNG</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 11, 1982</b>		2b. HOUR <sup>A</sup> <sub>M</sub> <b>10:20</b>		
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 21, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>72</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE CLINICAL CENTER, NIH</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>LAUREL</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6608 WEAVER COURT (20810)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MORRIS CAREY</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA COURTNEY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-38-5695</b>		17. INFORMANT <b>MR. CAREY BRADY</b>		ADDRESS <b>410 PRINCE GEORGES STREET LAUREL, MARYLAND 20707</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1830</b> IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ovarian carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>DECEMBER 29, 1981</b> , to <b>JANUARY 11, 1982</b> , that <del>we</del> (we) last saw the deceased alive on <b>JANUARY 11, 1982</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gerald Batist</b>				DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1-11-82</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gerald Batist</b>				22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205</b>					
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>BURIAL</b>		23b. DATE <b>JANUARY 14, 1982 MD.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL MEM. PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAUREL, MARYLAND</b>			
24. FILED IN _____				25. DATE REC'D BY REGISTRAR <b>JAN 18 1982</b>		26. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			

CONFIDENTIAL



CONFIDENTIAL

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Adolph J. Ziese		1 26 82		940 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE	WHITE	DEC. 30. 1898		83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
GERMANY	U.S.A.			MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
TAKOMA PARK	WASHINGTON ADVENTIST HOSPITAL		UPHOLSTERER		SAME (RET.)
13a. STATE		13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS
DIST. OF COL.		WASHINGTON	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7121 8th ST. N.W.
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
HEINRICH ZIESE		KATHRYN LUCIKEN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		577-01-5112		HENNY D. ZIESE, 7121 8th ST. N.W. DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Bilob Pneumonia					3 day
DUE TO, OR AS A CONSEQUENCE OF (b) Gun Wound Extremity					4 day
DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Tract Inf.					2 wks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)					
severe dementia Ex hip CVA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
12-29-82		Hip Pinning		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-27-82, 1982, to 1-26-83, 1983, that (I) (we) lost saw the deceased alive on 1-26-83, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
R.H. Sandstrom MD				1-26-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
R.H. Sandstrom MD		7701 Carroll Ave Takoma Park, Md 20912			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		JAN 29 1983		PROSPECT HILL CEMETERY	
23d. FUNERAL DIRECTOR		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
J. Arthur Walters		JAN 20 1983			
J. Arthur Walters		254 Carroll St. N.W.			

